


AUG 1922

Medical Lib.

CALIFORNIA STATE JOURNAL OF MEDICINE

RESOLUTION ON "SHEPPARD-TOWNER LAW"



- "HEREAS, The Sheppard-Towner law is a product of political expediency and is not in the interest of the public welfare, and
- "WHEREAS, The Sheppard-Towner law is an imported socialistic scheme unsuited to our form of government, and
- "WHEREAS, The Sheppard-Towner law unjustly and inequitably taxes the people of some of the States for the benefit of the people of other States for purposes which are lawful charges only upon the people of the said other States, and
- "WHEREAS, The Sheppard-Towner law does not become operative in the various States until the States themselves have passed enabling legislation, therefore be it
- "RESOLVED, That the American Medical Association disapprove the Sheppard-Towner law as a type of undesirable legislation which should be discouraged."—(*Abstract from Minutes of the Seventy-third Annual Session of the A. M. A.*)

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No. 8

ORIGINAL ARTICLES

RESPONSIBILITY FOR STATEMENTS AND CONCLUSIONS IN ORIGINAL ARTICLES

The author of an article appearing in the JOURNAL is entirely responsible for all statements and conclusions. These may or may not be in harmony with the views of the editorial staff. Furthermore, authors are largely responsible for the language and method of presenting their subjects. All manuscripts will be carefully read, but editorial privileges will be exercised only to a very limited extent. It is believed that the manner of presentation of any subject by any author determines to no small degree the value of his conclusions. Therefore, both the author and the reader, in our opinion, are entitled to have the subject as presented by the author as little disturbed as possible by the editors. However, the right to reduce or reject any article is always reserved.

NON-DYSENTERIC AMEBIASIS *

By ALFRED C. REED, M. D., San Francisco.

The term "amebiasis" was coined in 1904 by Musgrave and Clegg in Manila to describe a "state of infection with amebas," and we are extremely fortunate here today in having with us in person one of the originators of this term, Dr. Musgrave, who has had the rare privilege of observing the development in this country and abroad of work stimulated and begun by himself twenty years ago. Man is subject to infection by at least five varieties of ameba. Of these we are convinced of pathogenicity in the case of one only—*Entamoeba histolytica*. Kofoid and his colleagues have described as *Councilmania lafleuri*, a species of ameba which they believe to be pathogenic and to have been confused formerly with *Entamoeba coli*. At present this species is under judgment, and its establishment as a new species is open to serious question, so that we can speak with unanimous authority of only one ameba, *E. histolytica*, whose pathogenic properties have been clearly demonstrated. This species alone, therefore, enters into the present discussion.

Amebiasis is widespread in the human race, some authorities estimating that as high as 10 per cent of the population of the globe is infected. An examination of 2300 overseas men and 576 home service men by Kofoid and Swezy led these workers to conclude that carriers of ameba in the United States were greatly increased by the return of the soldiers, and that carriers are more numerous than was expected among the normal population. Giffin, as early as 1913, in 1700 persons

examined in the Middle Northwest, found 148 infected with *E. coli*, and 79 with *E. histolytica*.

In California there is evidence of a surprisingly high incidence, as indicated by numerous case reports and surveys. The sources of the endemic distribution in California are chiefly these:

1. Immigration from the Orient, especially of Filipinos, Chinese, Japanese, and East Indians.
2. Immigration and transient labor from Mexico.
3. Tourist travel from California to Asia.
4. The army demobilization.
5. Trade routes centering in California ports.

As in the case of other typically tropical diseases, so here, we have in California special problems and special dangers which require immediate attention.

While until recently considered predominantly a tropical affection, amebiasis is now known to be cosmopolitan and to invade practically every country of temperate climate as well as the tropics. There seems, however, to be a clinical difference in that dysentery is by far a more striking feature in the tropics than in higher latitudes. The common use of the term, tropical dysentery, as a synonym for amebic dysentery, is an illustration of this. It is important to keep clearly in mind that dysentery is merely a syndrome and not a specific disease. By dysentery we mean frequent bowel movements, containing blood and mucus and associated with pain and tenesmus. Dysentery is due to a large variety of causes of which ameba is only one.

An understanding of amebiasis from the clinical point of view requires an exact knowledge of its pathology and of the life cycle of the ameba. Under no circumstances are motile amebas in the dejecta infective for human beings. Their viability is too feeble and they probably never survive passage through the human stomach even if they get this far. Infection of man occurs solely through the agency of cysts. The vectors concerned in this transmission are chiefly water and flies. The cysts ingested by flies are found fully potent in their feces. Dependence on cyst-transference explains why amebiasis is invariably endemic and never epidemic in its incidence.

The cysts are ingested with food or drink by man and pass unchanged through the stomach. In the small intestine the cyst wall is dissolved and probably a single small quadri-nucleate ameba is released. This soon subdivides into four new

* From the Department of Medicine, Stanford University Medical School.

amebas which are carried by the intestinal flow to the colon.

Many authors have described invasion of the small intestine, but almost invariably the colon alone is attacked and the sites of election are the flexures, cecum and rectum. Dobell describes one method of invasion. In this the amebas are seen to congregate in large numbers on the surface of the healthy mucous membrane and gradually erode it by the secretion of a cytolytic ferment which dissolves the epithelial cells. The amebas soon lie in a pool of liquefied epithelium. Dobell states that they do not dislodge the epithelial cells mechanically or burrow between them. They do, however, according to this author, frequently invade the tissue through the crypts of Lieberkuhn. This is a stage of superficial erosion only and while the adjacent capillaries are dilated there is no true tissue reaction.

This erosion may develop into the characteristic type of amebic ulceration. The cytolytic action of the ameba here seen, gives the occasion for the name *histolytica* and is the one and only definite indication of the production by the ameba of an exotoxin. The ameba lives in direct contact with healthy tissues and not in the necrotic mass resulting from its activities.

Dobell describes the histologic picture as follows:

There first occurs a histolysis of the tissues in direct contact with the ameba and then a dilatation of the nearby capillaries with succeeding thrombosis and round-cell infiltration. Finally a necrosis of varying extent takes place. The typical amebic ulcer gives the appearance of a purely local lesion, with very little if any tissue reaction. The body tissues tend to regenerate whenever and wherever the amebas cease their activity or are removed by specific treatment. Some scar tissue is formed as well as new replacement tissues. The amebas are present in the lesions in vast numbers, in a large motile form. It is probably here that reproduction takes place by simple fission. A certain number of these large amebas, the ones destined for race propagation in a new host, leave the tissues and pass into the lumen of the colon where they are reduced in size and extrude all foreign material and food masses. Then as small, round, clear and very sluggish forms, they proceed to encyst by merely secreting a transparent thin coating. These cysts are carried out by the intestinal contents and their single nuclei subdivide twice, giving an ordinary maximum of four nuclei in the cysts seen in the stools.

Cyst production is not a constant activity of an ameba colony. It does not occur in amebic abscesses as in the liver or brain. Nor does it occur with any regularity in intestinal lesions. The biologic reasons for this are obscure but doubtless have to do with the lack of drainage of necrotic material, giving in general thereby an absence of any means for propagating an extension of the infection to a new host, and with the fact that the ameba under such conditions is not in an optimum environment for both forms of reproduction.

Under conditions favorable for its growth and reproduction, the ameba exists in a free-moving form, while under less favoring environment and when preparing for departure from its human host, it encysts in a resistant resting form. We have no evidence that under any circumstances *E. histolytica* can inhabit the human colon as a harmless commensal. As the infection increases in quantity and virulence, the clinical picture approaches that of dysentery. On the other hand, as the infection is less massive and vigorous, the clinical picture is that of non-dysenteric amebiasis, that is, of a carrier or chronic state. As various authorities have pointed out, granted an amebic infection, it is evident that this chronic or non-dysenteric state is the optimum both for parasite and for host. Non-dysenteric amebiasis is much more prevalent in temperate climates while dysentery and abscesses are more frequent in hot climates.

Several comments arise out of this survey of the pathology and life history.

1. All forms of amebiasis, in our present state of knowledge, pre-suppose and require that primary form of intestinal infection just described.

2. The ameba can invade the blood and lymph stream with the utmost ease. This is further proved by the occurrence of liver and brain abscesses. But thus far, no portal of entry has been proved except the one noted through the intestine.

3. While the ameba gives evidence of secreting a histolytic exotoxin, no other evidence of exotoxic action has been clearly demonstrated.

4. All clinical symptoms resulting from the presence of ameba in the body must be due to the following mechanisms:

- (a) The effect of local pathologic changes in the intestine or other tissues directly invaded by the ameba.

- (b) Absorption of amebic exotoxins of a more or less hypothetic nature.

- (c) The absorption through amebic lesions of virtually parenteral protein or bacterial products. This latter is probably the explanation for the inflammatory reaction and enlargement of lymphatic glands draining regions of amebic invasion.

- (d) Reflex effects resulting from the presence of amebas in the colon or elsewhere. If an inflamed appendix can be responsible for a reflex constipation, it is equally conceivable that an amebic lesion can cause intestinal and digestive disturbances through a reflex mechanism.

As seen in California, amebiasis in the great majority of cases is of the non-dysenteric type; that is, the infection exhibits an approximate balance between host and parasite and is apt to manifest itself in symptoms which are not a direct result of the lesion in the intestine. Almost any variety and degree of neurasthenia, physical depression, constipation, loss of weight, anemia, digestive troubles, vague aches and pains, and indefinite ill-health may be associated with amebiasis and disappear when the ameba is eliminated. In fact the symptoms may be so diverse, bizarre and unexpected that amebiasis is the last possibility to

be considered. This type of symptomatology is prevalent in California. In view of these considerations the following clinical rules may be drawn with conservatism:

1. Amebiasis is prevalent in California in non-dysenteric form.

2. Every patient suffering from gastro-intestinal symptoms should be investigated for the presence of ameba.

3. Every patient in whom the diagnosis is obscure or incomplete should be investigated for ameba.

Identification of ameba in the stools must include at least six consecutive daily specimens, including formed as well as fresh liquid stools, and must be conducted by a competent parasitologist.

Pathogenic amebas, that is, *E. histolytica*, have been described with certainty only in the intestine and in secondary abscesses as in the liver, lungs and brain. Reports of their occurrence elsewhere in the tissues of the body are subject to more or less criticism and are either inaccurate or premature at the present time. By many writers pathogenic amebas have been described in the urine and urinary bladder. Some few of these reports may be correct but the majority cannot be studied without the growing conviction that inflammatory or body tissue cells have been confused with amebas. We must recall that the leucocytes of normal blood have an ameboid motility and a cytology distinguishable with the utmost difficulty in fresh preparations from motile pathogenic amebas. This point was called to my attention by Herbert Gunn, who has been able to demonstrate the close similarity of fresh leucocytes with various wandering tissue cells, pus cells and amebas. Error is difficult to exclude. Always study of the free-moving forms must be amplified by identification of cysts when they occur, description of the nuclear structure and study of stained preparations before a valid opinion can be given. These criteria have not been met in the great majority of cases where amebas have been reported present in the urinary tract and elsewhere in the body outside the points of recognized incidence.

The same criteria may be brought with equal force against amebas reported in any tissue, as in the skin for instance. In the case of bile infections, a final word cannot be given. Gunn has had cases, one of which he has reported, where intestinal amebiasis cleared temporarily after removal of the gall bladder which apparently contained motile amebas. Permanent cure was prevented possibly by amebic infection in the bile ducts. It has been supposed that ameba would not live in the presence of bile so here, too, further light is needed.

There is little question that many persistent cases of amebiasis depend for their chronicity on an amebic focus in the appendix. It is probable that removal of the appendix would cure many such cases just as effectively and much more quickly than appendicostomy and colon irrigation through the stump. Skin infections have been described, partaking of the nature of a phagedena and associated with sinuses from a deep amebic

abscess as in the liver. It is conceivable that amebas might infect cutaneous tissue by this method but the proof of it is not very definite.

The problem of the relations of ameba to the lesions of arthritis deformans, Ely's second great type of arthritis, has received considerable study in the past year at the Stanford Medical School. For several years claims have appeared in literature that ameba was related to this hypertrophic type of chronic osteo-arthritis. In 1906 Hunkin and Long, in San Francisco, attempted to show such a relationship. Since then John Barrow of Los Angeles has claimed that the relationship existed.

In the late summer of 1921 Barrow found *E. histolytica* in the stools of one of Ely's patients who suffered from hypertrophic arthritis of the spine. Relief or improvement not having followed the usual methods of treatment, this patient was given a course of specific amebic treatment with an immediate and remarkable clinical improvement. One relapse of arthritic symptoms was accompanied by a recurrence of cysts in the stools and the symptoms disappeared with a continuance of treatment. A second relapse was not accompanied by any evidence of intestinal amebiasis but improvement again followed resumption of amebic treatment, and has continued.

About this time Ely removed the head of a femur for this type of arthritis. Sections from the necrotic areas of this bone were stained with a standard iron hemotoxylin method and showed cellular bodies identified as *E. histolytica*. These bodies were abundant near the periphery of the necrosis and especially abundant around the capillaries. Their identification as amebas has not met with unanimous confirmation from those who have examined the sections. They were studied by Kofoid, who has already this afternoon detailed his conclusions about them. In an earlier note Kofoid and Swezy make the following statement:

"A portion of the head of a human femur, removed by operation in a case of arthritis deformans, reveals a pure infection of amebae about the characteristic lesions in the bone. No stained bacteria have been found in our examination. . . . The organisms interpreted by us as amebae are unlike known normal or pathologic tissue cells. They have the clear nuclear structure of *Endamoeba dysenteriae* (Councilman and Laffeur) found in tissues about amebic ulcers in intestinal amebiasis. Their nuclei are unlike those of *Endamoeba gingivalis*."

Ely, Wyckoff and I have continued investigation of these lesions and have examined the stools in twenty cases of Type II arthritis in the clinic service. Of these only one showed histolytica. This patient was put on intensive treatment for amebiasis with the result or accompaniment that his arthritis became distinctly worse and remained worse. Cysts had not reappeared in his stools within two months after stopping treatment but physiotherapy had to be resumed to relieve his pain.

During the same period I saw seven other cases

of Type II arthritis. One only of these, the case already mentioned as the original in this series, harbored *Entamoeba histolytica*. One of these which had no evidence of amebiasis was put on moderately severe amebic treatment none the less and received immediate improvement which has lasted for some two months. I believe the explanation lies in the free elimination secured by the treatment and is along the line frequently noted of improvement following the use of colon irrigations and a diet designed to decrease putrefactive changes in the bowel. A second case was infected with an ameba which Kofoid diagnosed as Councilman's. The amebiasis was cured by specific emetin treatment and the clinical improvement was marked and has lasted some three months. Such a so-called therapeutic test as this seems to me worthless, however, as showing any relations between ameba and arthritis, for the same reason as stated above.

It is evident that bony changes in hypertrophic arthritis will outlast removal of the specific cause whatever that may prove to be, and it is more than possible that the symptoms of arthritis would persist likewise after removal of the specific cause. Effective treatment probably must be instituted in the early stages of the bone pathology and preferably on a preventive basis. Immediate improvement in the symptoms of arthritis after treatment with emetin preparations would in no sense argue for an amebic cause for the arthritis, but rather for immediate removal or subsidence of some focus of toxic absorption in the intestine. This is in line with mature clinical judgment.

Settlement of the present question of the causative relationship of the ameba will depend not on therapeutic experimentation but on demonstration of definite association histologically between ameba and bone lesion, and the experimental production specifically of such lesions.

It might be assumed that a comparison of the rate of incidence of ameba in Type II arthritis cases as compared with the rate of incidence at large would give conclusive evidence for or against the thesis that ameba is the cause of osteo-arthritis. But it is to be remembered that such statistics are at best only of inferential value and what value they possess is strictly proportioned to their quantity. Definite pathologic evidence alone would satisfy the requirements of the case.

This investigation is tedious and slow in its development and a considerable time will be required to affirm or disprove the suggestion that ameba is related to arthritis. Ely finds alveolar infection almost universal in Type II arthritis, yet the bone lesions seem without question to be non-bacterial in origin and, moreover, the *E. gingivalis*, so frequently associated with abscesses and granulomata in the dental area, has so far not been proved pathogenic. In a recent case of intestinal amebiasis, we examined the carious bone resected for the removal of deep dental infection. In the dental abscesses and granulomata *E. gingivalis* was abundant but no ameba-like cells of any sort were found within the bone itself. Neverthe-

less we are not yet prepared to state positively that the alveolar process can never be a portal of entry for pathogenic amebas.

Clinical experience thus far is too small to warrant statistical conclusions and for the purpose involved here, the importance of statistics is certainly minimal. We know that in other regions ameba may leave certain areas and move on or disappear, and the same factor doubtless would play a part if amebic bone infection were to occur.

There is, on the other hand, no evidence that amebiasis ever terminates spontaneously in the absence of specific treatment. Our personal impression is that the matter of bone invasion by ameba requires adequate investigation and that the suggestive data at hand amply justify further study. Lacking a bacterial cause for arthritis deformans, we can with logic seek a protozoal cause. Barrow believes that protozoan infection is present in 100 per cent of Type II arthritis. It will be necessary to demonstrate motile amebas in the fresh bone tissues, as cysts are not to be expected in such a location. As *E. histolytica* has not yet been successfully cultivated, experimental lesions are extremely difficult to secure at present.

While it is not certain that the intestinal tract is the sole portal of entry for pathogenic amebas, still thus far no other has been demonstrated. Treatment of intestinal amebiasis, therefore, might react favorably on a bone lesion in a non-specific manner by decreasing absorption of bacterial or protein products through intestinal ulcerations. The field of investigation is large and many unknown factors are doubtless involved. It is possible that a food deficiency analogous to a scorbutic deficiency may determine the bony localization of a protozoan parasite. We are convinced in any case that the inquiry must proceed along pathologic and experimental lines rather than in the hope of data from therapeutic or statistical methods in well-established cases of arthritis.

An unusual case of amebiasis was seen recently through the kindness of W. H. Barnes of San Francisco who reported it at the April meeting of the Stanford medical staff, and who intends to publish the detailed case report after longer observation.

A young woman, who had served as an army nurse, had suffered for five years from attacks of unusually severe asthma. During the same period she had recurring periods of diarrhea and sometimes of dysentery. No cause being found for the asthma, the stools were finally examined and *E. histolytica* was found in heavy infection. Specific treatment resulted in the temporary disappearance of the ameba and also in immediate relief of the asthma. Recurrence of ameba in the stools for a considerable period were concomitant with recurrences of severe asthma, which each time were relieved by specific treatment for amebiasis. Finally a more severe course of treatment was instituted with the hope of entirely eradicating the ameba, and in the course of the treatment she developed a severe arthritis. This is her status at present and Barnes' future report will record the end results.

Ordinarily asthma in the course of amebic infection is not affected by treatment for the latter.

The striking coincidence of the asthma and the intestinal symptoms and their common relief by specific amebic treatment are remarkable. The relation, if any, of the arthritis to the other conditions present has not yet been suggested.

In the treatment of amebiasis we believe that ipecac and its alkaloids alone are of value. Emetin hypodermically and bismuth emetin iodide by mouth are the only two preparations used, with the occasional addition of ipecac root. Neosalvarsan is added on the strong recommendation of Herbert Gunn who has found it to increase the efficiency of treatment. The bismuthous emetin iodide is given in powder form in gelatin capsules, three grains at night, if necessary preceded by opium. This drug is difficult to take and sometimes cannot be used in full dosage. Colon irrigations and oil enemas are used where there is evidence of marked colitis. Under like conditions the treatment is initiated by a short course of ipecac powder in massive doses. Other drugs are used solely for symptomatic indications, as for the benefit of digestion or the relief of colitis which may and often does outlast eradication of the ameba. Synthetic emetin is under trial at the suggestion of Barrow.

Treatment should be intensive and repeated milder courses administered in case of recurrence of cysts in the stools. Some cases have received definite benefit by resumption of mild treatment for purely symptomatic reasons when no cysts could be discovered. Alcresta ipecac is used at times for this purpose. It is mild in action, and much weaker than other ipecac preparations named, probably due to its admixture with kaolin.

The chief criterion of cure of amebiasis is the absence of cysts from the stools for a period of at least three months after termination of treatment. Examination for cysts, as already stated, requires at least six consecutive specimens on different days, including formed as well as fresh liquid movements.

In our investigations at the Stanford Medical School the stool examinations have been under the direction of Harry A. Wyckoff, clinical pathologist at Stanford Hospital.

(350 Post Street)

USING MEDICAL TERMS BEFORE PATIENTS

During the days when frock coats and whiskers were part of the physician's stock in trade, it was quite the custom for physicians to bewilder and frighten the patient by discussing his illness in Latin or in technical terms the patient could not understand. This custom should have disappeared with the frock coat, but it has not entirely done so.

The practice is and always was a deplorable example of poor taste, and now it is no longer legally safe. Many patients are sufficiently acquainted with the technical terms to understand, while others misunderstand and cause themselves worry and unhappiness.

In a number of court actions recently, physicians have been required to substantiate thoughtless statements made at the bedside, and it is likely that evidence of this kind will play a more and more important role in malpractice suits as time goes on.

A PLAN FOR THE INTENSIVE TREATMENT OF CONGENITAL SYPHILIS

PRELIMINARY REPORT

By HERMANN SCHUSSLER, JR., M. D., San Francisco.

The average physician, more particularly the general practitioner, has always considered the treatment of congenital syphilis as a most unsatisfactory part of his work. While many patients, especially young infants, show a strikingly clinical improvement under the influence of mercury alone, yet the Wassermann reaction is hardly ever made negative even when this drug is long and faithfully continued. The late case, with interstitial keratitis or a bone lesion, is generally looked upon as essentially incurable. Furthermore, many physicians feel that intensive arsenical therapy is either too difficult, too dangerous, or too painful to be used in infants and young children, except perhaps in the hands of one highly trained, and with all the facilities of the modern hospital at his disposal.

Recently Fordyce and Rosen, and Jeans have presented evidence that by following out in congenital syphilis a systematic plan of treatment similar to that used in adults, remarkable results can be obtained. Infants were apparently cured within a year, and most older children in two years. The methods described by these writers are not only efficient but safe, and simple enough to be carried out by anyone with medical training.

For the past two years we have been gradually improving, simplifying, and systematizing our routine plan of treatment for congenital syphilis at the Children's Clinic of Stanford University Medical School. Our aim has been to develop a method which the general practitioner can apply in the office or the home with a minimum of apparatus and trouble, with little or no discomfort or risk to the patient, and with the assurance that all the advantages of modern intensive anti-syphilitic therapy have been brought to bear upon the case. The method as it now stands may require further changes in the future, but we feel that the work has progressed far enough to justify this preliminary report.

General Plan of Treatment—When the Wassermann report comes back positive, the parents are carefully instructed as to the nature of the infection, the prognosis to the child with and without treatment, and the importance of regularity in attendance and of following out instructions to the letter. Wassermann tests are done on the parents and their other children, and the importance of treating the mother during future pregnancies is emphasized. The whole-hearted and faithful co-operation thus secured has contributed markedly to our good results.

If no contra-indication is found in the physical examination, the following course of treatment is begun at once:

1. Three intravenous injections of neoarsphenamine are given at 48-hour intervals.
2. Three mercurial inunctions are given every week for eight weeks.

3. Three more neoarsphenamine injections are given at 48-hour intervals.

4. Mercurial inunctions are given as above for four weeks more.

5. A rest period of four weeks is permitted, at the end of which a Wassermann test is done.

It will be noted that the above schedule covers a period of about four months. It is repeated regularly until the Wassermann test is negative, after which one more course is given with step 3 omitted. Then all treatment is stopped, and the Wassermann is repeated every six months for three years. If all are negative, and no clinical evidence of the disease has appeared, the patient is considered as probably cured.

Perhaps a longer observation period would show some late relapses, but we believe that three years are sufficient for all practical purposes. We have given up the provocative Wassermann reaction as unreliable, and feel that routine spinal puncture before dismissal is not necessary in children.

Sodium iodide is given almost continuously to all patients over one year old, being omitted and a tonic of iron and cod liver oil substituted during the rest periods.

If the patient has an active or open lesion, the initial series of neoarsphenamine is increased to six injections on alternate days, the rest of the course being as usual. This first course is considered the most important, and it should be made intensive. In weak athreptic infants, the first arsenical series may be preceded by a week or two of mercury rubs.

Spinal puncture is done (1) if the central nervous system is clinically involved; (2) if the Wassermann reaction is very resistant to treatment; (3) in cases with mental deficiency, and (4) at the time of the first negative blood Wassermann, if involvement of the nervous system has ever been suspected. Intraspinal treatment in children is rarely used and is not recommended for general practice.

Adenotonsillectomy and extraction of diseased teeth should be done whenever indicated, not only because the child's general condition is improved by the operation, but because the clinical and serological response to treatment often becomes far more rapid and satisfactory after the removal of focal infections. The first rest period is usually the best time for such surgical measures.

Dosage—The dosage of neoarsphenamine varies with the age, weight, arsenical tolerance, and general physical condition of the patient. It is much higher, in proportion, than the doses commonly used in adults. We have never seen a serious reaction from it when given as advised in this paper.

The ampules are made in six sizes, and the following table indicates the usual weight-range for each size, as well as the amount of water generally used to dissolve the dose:

Dose	Weight-Range	Water
0.15 g.	Under 12 pounds	0.5 cc.
0.3 g.	12-22 pounds	1. cc.
0.45 g.	22-35 pounds	1.5 cc.
0.6 g.	35-50 pounds	2. cc.
0.75 g.	50-70 pounds	2.5 cc.
0.9 g.	Over 70 pounds	3. cc.

Of course, in any case whose arsenical tolerance is doubtful, the initial dose should be about half the usual one for the patient's weight.

The mercury is prescribed as flexible capsules, each containing 4 g. of the official 50 per cent Unguentum Hydrargyri. Parents and children are instructed to rub for 30 minutes or until the skin no longer feels greasy, after which the excess may be removed with benzine and cotton. Infants under 20 pounds are given two inunctions a week of half a capsule each, using alternately the front and back of the body from neck to knees. Children between 20 and 50 pounds get half a capsule three times a week, the areas used being (1) chest and abdomen, (2) back, and (3) both legs from hips to ankles. Children over 50 pounds get a whole capsule three times a week, using the same areas. Older children do the rubbing themselves, except when the back is used.

Sodium iodide is prescribed in saturated solution, one or two drops for each year of age three times a day after meals, given in a full glass of milk. The initial dose is often smaller as a precaution, although we have seen no iodism. Larger doses than those given above are probably never necessary, even when gummata are present.

Half a teaspoonful of powdered sulphur at bedtime every night is an efficient prophylactic against mercurialism, as well as a useful treatment for this condition when it occurs. In the rare cases in which a gingivitis developed, the sulphur cleared it up rapidly, although the mercury was continued without interruption. When mixed with a little syrup, children take it without objection.

Neoarsphenamine Technique—We use a modification of Schamberg's technique. A 2 cc. glass syringe, an ordinary Wassermann needle, and a half-inch, 25 gauge hypodermic needle comprise all the apparatus required. After sterilization, the specified amount of boiled fresh tap water is drawn into the syringe, and the larger needle attached. Distilled water, and larger amounts of water than those given in the table, are unnecessary. The small tip of the ampule is filed and knocked off, the powder shaken to break up lumps, and the cooled water injected. The finger-tip, wiped off with alcohol or covered with a sterile finger-cot, is placed over the small hole, and the ampule is well shaken until solution has occurred, usually in less than one minute. The solution is now drawn into the syringe from the inverted ampule. The large needle is then replaced by the smaller one and the injection given *at once* to prevent oxidation.

Children of over six years usually have good veins at the bend of the elbow. In all others the external jugular is probably the best, although young infants often have good scalp veins which may be used. We no longer use the fontanelle, and do not recommend it. Crying, or digital pressure above both clavicles simultaneously, will distend the jugular and scalp veins nicely. For the former, the head should be hyperextended and rotated, with a pillow under the shoulders. The skin is washed with 95 per cent alcohol, as 70 per

cent leaves it slippery. The distended vein and overlying skin are drawn taut by the operator's left thumb. The small needle is introduced well into the vein by a quick stab, which is practically painless. When the blood enters the syringe by gentle traction with the plunger, and the point is known to lie free in the vein, the digital pressure is released and the injection is made slowly, taking about one minute. When the syringe is empty, 0.5 cc. of blood is aspirated and reinjected, to rinse out the last drops of solution and prove that the needle was in the vein throughout. Obviously, the child must be prevented from struggling during the treatment. Most children are quiet after their first experience.

This technique is no more difficult than that required for other intravenous medication. It takes less than five minutes to give a treatment, and the same vein often may be used repeatedly. The small syringe and fine needle make these intravenous injections simple even in the smallest vein. We have never had to cut down on a vein, and have given up rectal and intramuscular administration entirely.

Comment—The dosage and intervals recommended above have been reached very gradually and they appear to be the most satisfactory ones for general use. Whether children tolerate neoarsphenamine better than adults, or whether the customary dosage in adults is too small, is not certain. However, our dosage is safe, and has been exceeded on several occasions without untoward results. In view of the low toxicity, high efficiency, and ease of administration of neoarsphenamine, we feel that it should entirely replace arsphenamine in the treatment of children. It is extraordinary to one accustomed to giving 0.6 g. of this drug once a week to an adult to see a child weighing 35 pounds taking the same dose every other day for six doses with no sign of a reaction. Reactions, other than a little vomiting at times, are practically eliminated by omitting luncheon, making breakfast and supper light, giving a mild laxative the night before if the child has been constipated, and giving the injection between 11 a. m. and 3 p. m.

The 48-hour interval recommended by Ormsby is safe and far more efficient than the longer intervals in common use. In following somewhat similar methods we have not observed anything suggesting a cumulative toxic effect.

The contra-indications to the various drugs employed are the same in children as in adults, but are comparatively rare. None have occurred in our series. The occasional appearance of a trace of albumen and a few hyaline and granular casts in the urine during the administration of the neoarsphenamine may be disregarded, as they always disappear rapidly after the last injection, and do not indicate nephritis.

Inunction is the method of election in giving mercury to children. Mouth administration clears up lesions and increases weight, but does not affect the Wassermann reaction and also has the other well-known disadvantages. Ramsay and Groebner have shown, by quantitative analyses of the urine

for mercury, that absorption after proper inunctions was greater than after any other method which they tested. They also showed that daily inunctions are unnecessary, and since we have adopted the present plan of two or three rubs a week, no patient has failed to carry out his part of the program faithfully. We have seen no salivation, diarrhea, or dermatitis.

RESULTS AND CONCLUSIONS

While a number of our patients have been rendered Wassermann-negative, and all have shown marked clinical improvement, as evidenced by disappearance of lesions, gain in weight and strength, and better work in school, yet we feel that a statistical presentation of our results should be postponed until a longer observation period has elapsed. The hope of the congenital syphilitic lies, we believe, in more systematic planning of his treatment, in its continuance beyond the first negative Wassermann, and in the use of larger and more frequent doses of neoarsphenamine than have heretofore been customary. In any case we are more than satisfied with the progress our patients are making, and feel that our plan of treatment, while extremely simple and easily mastered by anyone, is as effective and as well borne as any that has heretofore appeared in the literature.

(391 Sutter Street)

Resolution on Chiropractic Training of Disabled Soldiers—Abstract from Minutes of the Seventy-Third Annual Session of the A. M. A.

"Whereas, The St. Louis Medical Society on May 16, 1922, by Memorial and Resolutions vigorously protested against the approval by the U. S. Government of the School of Chiropractic as a means of vocational training for disabled ex-service men, and

"Whereas, It appears that more than 250 ex-service men from all parts of the country, seventy of whom represented the Ninth District, composing the States of Missouri, Iowa, Kansas and Nebraska, are now enrolled in one Chiropractic School in this district with the sanction and approval of the U. S. Government; therefore, be it

"Resolved, That the House of Delegates of the American Medical Association, in annual session assembled, representing over 89,000 legally qualified physicians, adequately trained in the arts and sciences (the only foundation for the recognition, control and prevention of disease), approves the sentiments expressed in the Memorial and Resolutions adopted by the St. Louis Medical Society, which have been submitted to this House, and hereby directs that the proper officers of the American Medical Association memorialize and petition the Federal Government, particularly those officers charged with the responsibility for the rehabilitation of disabled ex-service men, and to take such action in the interest of the welfare of all the people, and also for the protection of those who honestly desire to administer to the sick, to the end that the ex-soldiers seeking vocational training, which will fit them for administering to the sick and aiding in the recognition, control and prevention of disease, shall, at least, meet the requirements and shall receive such adequate training as is defined in the classification of medical schools of the American Medical Association, known as Class A, or acceptable medical schools—a standard which is approved by all right-thinking people moved by a desire for public welfare."

THE DIPHTHERIA PROBLEM

By W. W. ROBLEE, M. D., Riverside, California

Notwithstanding a fairly complete knowledge as to etiology, methods of immunization and specific treatment, diphtheria continues to take a serious toll of lives and is responsible for great economic waste.

Number of cases of diphtheria in New York City, 1920.....	14,166
Number of deaths from diphtheria in New York City, 1920.....	1,045
Number of cases of diphtheria in New York City, first six months, 1921.....	10,722
Number of deaths from diphtheria in New York City, first six months, 1921.....	611
Estimated cost for first six months, 1921.....	\$581,825
Number of cases in California, 1921.....	9,448
Number of deaths in California, 1921.....	637
Number of cases last two weeks in January, 1922.....	637
Total deaths annually in United States about.....	15,000

Prior to 1895, when antitoxin came into general use, the case rate was variously estimated at from 150 to 200 per hundred thousand. Many factors render it difficult to arrive at accurate figures, but apparently the disease incidence has been very little reduced during the past decade.

The mortality rate in pre-antitoxin days was 32 per cent.

The mortality rate at present is but 8 per cent.

This gives a mortality reduction of 75 per cent. or, in other words, antitoxin saves 45,000 lives annually, but the disease incidence remains stationary.

The object of this paper is to call attention to certain proven procedures, whereby disease incidence, in relation to diphtheria, may be greatly reduced. In fact, it is not an over-statement to declare that clinical diphtheria could be wiped out if universal application of these methods could be secured.

Two Necessary Factors in Diphtheria Control:

1. The spread of infection by:

(a) Carriers:

1 per cent of population, 4 to 8 per cent of children have either virulent or avirulent bacilli.

(b) Missed clinical cases:

- (1) Pharyngeal.
- (2) Nasal.
- (3) Laryngeal.

2. Detection of those non-immune by:

Schick Test. This was published in 1913 and used extensively by Behring in Germany eleven years ago and by Park & Zingher in New York for the past nine years. Over 100,000 children have been tested in New York during that period and numerous smaller groups elsewhere.

Technique of Schick Test:

1/50 minimum lethal dose of diphtheria toxin for a 240 gram guinea pig in a given quantity of salt solution, usually 0.1 cc., is injected intradermally, preferably on the anterior surface of the forearm and the same amount of the toxin heated to 75 degrees C. for ten minutes is given in the other arm. Dilutions must be freshly prepared each day.

The Toxin Reaction:

"Represents the irritant action of a specific toxin upon tissue cells that are not protected by antitoxin." It therefore shows a lack of immunity. The control test is for the purpose of detecting those who are sensitive to the proteins of the meat extracts and peptones used in the culture media and to the bacillary proteins that cannot be eliminated by any known method. In 24 to 72 hours a red area from 2 to 6 cm. in diameter develops; this is at its height on the fourth to fifth day and gradually fades, leaving a slightly scaly, brownish pigmentation which may persist for several weeks. Pseudo reactions develop quickly and are at their height in 24 hours. They disappear in three days. Defined as: (1) Positive; (2) Negative; (3) Positive combined, when both the toxin and control react; (4) Pseudo or pseudo-negative, a protein reaction.

There are no constitutional effects or painful local reactions from this test.

Results of the Toxin Reaction:

Age—Under six months all have maternal immu-

nity. From six months to five years nearly all are non-immune. After five years the immunity per cent gradually rises, probably due to mild repeated contact infections. The per cent positive varies in New York City from 15 to 67 per cent in various schools. Age, race, family and housing conditions have their influence. A fair average in children, including high school age, is 25 to 30 per cent positive. Therefore we can say that babies under six months have maternal immunity. Children from six months to five years should all be immunized without going to the trouble of giving Schick test. Children over five should be Schick tested and all positives immunized.

Artificial Production of Permanent Immunity:

1. Ordinary antitoxin immunity lasts only two to four weeks.
2. Toxin antitoxin.

A highly concentrated diphtheria toxin is slightly underneutralized by a concentrated antitoxin. One cc. of this mixture should give a small reaction in a 250 gram guinea pig. A 5 cc. dose should develop a paralysis in 15 days, and death of the pig two or three days later. It requires about six months to produce a stable standardized mixture and this will retain its stability for a year. Three of these 1 cc. doses at seven-day intervals are given. The toxin is neutralized to the extent of not being poisonous and yet it has the power to stimulate antitoxin production. The injection for all ages is 1 cc. of fluid, containing about 400 times the fatal dose for a half-grown guinea pig to which has been added slightly less than the antitoxin necessary to neutralize it. The reaction is usually slight, but in susceptible individuals may be fairly sharp. It is usually less than from typhoid-paratyphoid injections and more pronounced in those giving a positive combined reaction by Schick test.

Immunity:

Develops completely in about two months. Therefore it is of no service in the treatment of clinical diphtheria. Contacts can be immunized temporarily by antitoxin and in one month the permanent immunization done by toxin antitoxin; 85.5 per cent give negative reactions after five months. One or two additional injections should be given to the 14.5 per cent whose immunity is not complete. It is therefore wise to retest at the end of six months from initial immunization; 100 per cent remained immune after being handled as above by Park & Zingher in an institution five years ago. It is therefore safe to say that in all probability a complete permanent immunity can be developed by the above plan.

Cost of Immunization:

\$1.25 per patient when a small number are treated. When large numbers are to be immunized the expense is much reduced. It is estimated that the one million school children of New York City could be immunized for \$250,000, which is about \$332,000 less than diphtheria cost New York City during the first six months of 1921.

The objection has been raised by Cumming and others that Toxin-Antitoxin immunization is dangerous to the community for the reason that it does not destroy the infecting organism and that it in no way diminishes the number of carriers. That cities in which toxin-antitoxin protection is pushed will "become reservoir hosts of bacilli." There is no reason why efforts looking toward the elimination of carriers should be discontinued but the solution of that problem is at present hopeless. The one per cent of carriers in every city community and the activity of the various antagonistic cults renders such efforts largely of no effect. Doctor Park reports that deaths from diphtheria in New York City have been reduced from 1500 in 1918 to 891 in 1921, and he believes that both morbidity and mortality can be further reduced by a continuation of intensive work with the Schick test and toxin-antitoxin immunization. It certainly will solve the problem in schools or institutions where the inmates are under sanitary control.

Student nurses in every training school should be tested and immunized. It is our duty as physicians to call the attention of parents to the

fact that this dread disease can be prevented. My own children have been immunized and it was a great comfort to me a few weeks ago, when my little five-year-old daughter developed a membrane on her throat, to know that it would not result in the development of a laryngeal stridor and that she would not require sensitization by large doses of horse serum. It proved to be a streptococcus infection.

The efficacy of these measures in an institution was beautifully illustrated by an experience that we have had during the past year at the Sherman Institute Indian School, Riverside. In June a group of children from Arizona arrived at the school from a portion of the Navajo reservation, where diphtheria had been prevalent. On June 24 one of these pupils came down with clinical diphtheria. Others developed from time to time and as the school enrollment was low at that time of year, only about 300 pupils remaining, we cultured all throats and found 32, or 10 per cent to be carriers. These were isolated and released as they became negative, two requiring tonsillectomy. The disease was apparently controlled until October when, following entrance into the school of another group of children from a diphtheria-infected community, it again became prevalent, sixteen clinical cases developing before it finally came under control. There were at this time over 700 pupils enrolled in addition to which there were over one hundred white employees and members of their families on the grounds.

Early in December 641 pupils were Schick tested; of these 351 gave positive reactions. The positives were all immunized by three injections, at weekly intervals, of toxin-antitoxin, and also 53 Indians at the school farm and 17 white employees' children who were not given the Schick test, making a total of 420. The last dose was given December 24, 1921. The results obtained were most interesting. Four clinical cases of diphtheria developed after the last immunizing dose was given, two on January 5th, one January 15th and one January 20th. These were all very mild and did not require antitoxin for their cure. These cases bear out the observations made by others, that full immunity does not develop immediately, but that the severity of the case reaction gradually becomes lessened until full immunity at the end of about two months is developed.

During January, February and March, thirteen cases of tonsillitis developed, some of which showed membranes that could not be differentiated clinically from diphtheria. One case on February 28th suggested diphtheria so strongly that I gave antitoxin at once, but cultures when examined the next morning gave only a staphylococcus growth. No clinical cases of diphtheria developed among Schick negative students. Every check and cross check in this observation proved the fact that the Schick test and toxin-antitoxin immunization can be depended upon to control clinical diphtheria even under the crowded conditions found in a government Indian school in a group of young people with very low racial immunity.

I desire to acknowledge the helpful assistance of my associate, Dr. T. A. Card, in this study.

SUMMARY OF AN IDEAL PLAN FOR HANDLING DIPHTHERIA

- I. To Protect the Community:
 1. Clinical cases:
 - (a) Antitoxin treatment.
 - (b) Quarantine.
 - (c) Release after three negative cultures.
 2. Contacts cultured:
 - (a) Negatives released.
 - (b) Positives given virulence test.
 - (1) Isolate in open air.
 - (2) Mild alkaline gargle.
 - (3) Tonsillectomy if the carrier condition persists for a month.
 - (4) Release avirulent.
- II. To Protect the Individual:
 1. Schick Test all over five years to full maturity.
 - (a) Babies under six months maternally immune.
 - (b) Six months to five years all should be immunized by toxin antitoxin.
 - (c) Five years and upward Schick Test.
 - Immunize positives by three injections, 1 cc. toxin antitoxin mixture.
 - Retest in six months and further immunize those still positive.

The Country Doctor—The election of Thomas Clay Edwards as president-elect of the Medical Society of California has called forth a number of editorials and other comment from a number of papers of the State. Among these, the San Jose News, of May 26, 1922, says:

"A few weeks ago Dr. T. C. Edwards, for forty years a general practitioner in Salinas, was elected president of the California Medical Society. His election was announced as a 'tribute to the work of the country doctor for humanity.'"

"The tribute is well deserved by the country doctor. For while this is notoriously and flagrantly an age of specialization, basic general all around horse sense is a quality which is just as valuable as it ever was. The country doctor, the general practitioner, while he may occasionally blunder because he can't keep up with all the latest information on the progress of the various special divisions of the art he practices, yet seems to retain this grand old quality of basic horse sense to a great degree, whereas some of the specialists in medicine, as in other lines, seem to have more fancy zebra sense, or even jackass sense, than plain horse sense.

"Hurrah for the country doctor, the old fashioned general practitioner. He may have killed lots of people, but so has the specialist."

A Salinas paper of May 30, after paying splendid tribute to Dr. Edwards and complimenting the medical profession of the State for selecting a country doctor for its president, continues as follows:

"A lot of near-facetious comment, and 'smart aleck' cracks have been launched at the small town doctor. Just because he stays in the small town a lot of people get an idea that he isn't so efficient as his brother in the larger cities. That's all wrong. The big town chap handles only a certain line of diseases, 'Specialist' is what he calls himself. The country doctor is called to treat everything from an in-grown toe-nail to a broken back. Most of them could give the so-called 'city specialist' a close run in the latter fellow's particular line. You simply have to doff your tile to the country doctor. He's one grand scout. Generally he knows more community history, scandal and gossip than anyone in his section. But he's a close-mouthed business-like, genial, lovable mortal who undergoes a lot of things that would drive a lot of us to the goofy house. Salinas appreciates the honor done Dr. Edwards. Her people extend congratulations. The honor to him is no less an honor to every doctor in Salinas, and—for that matter—to every country doctor in the whole land. May God bless 'em—every one of 'em."

IS THE MELTZER-LYON TECHNIC FOR THE DIAGNOSIS AND TREATMENT OF GALL BLADDER DISEASE AN ASSET OR A LIABILITY?*

By WALTER C. ALVAREZ

PART I.

In 1917 Meltzer suggested, first, that inasmuch as the sphincter at the end of the common duct presumably must relax when the gall bladder contracts, if the contents of the gall bladder are to be extruded into the duodenum, the activities of the sphincter and the bladder must be coordinated and under the control of the "Law of Contrary Innervation." Second, if this be true, magnesium sulphate, when it relaxes the sphincter, must theoretically cause a reflex contraction of the gall bladder. Third, if magnesium sulphate were to be injected into the duodenum, it might help in overcoming jaundice and biliary colic.

The third suggestion was immediately put to the test by Vincent Lyon of Philadelphia. He observed that when the duodenal tube is first passed into the bowel, little or no bile can be withdrawn. Shortly after the injection of the magnesium sulphate, yellow bile appears; and shortly after that, there appears a darker and sometimes thicker bile. He assumed that the darker bile must come from the gall bladder, and the next step was to diagnose cholecystitis by the finding in this bile of pus cells, crystalline material and bacteria. Another step was to try to cure cholecystitis by repeated "drainages."

Certainly if Lyon is right in his contention this new method of diagnosis and treatment will be a great asset to the medical profession. If, however, the method is not based on a solid foundation; if it will lead to the making of wrong diagnoses and the performance of unnecessary operations; if it will cause physicians to waste their time and their patients' time and money; and if it will encourage patients to go on with futile medical treatment until old age, starvation, myocarditis and other complications bar the way to surgical relief, it will be a liability. As I have seen of late a number of cases in which the use of the method was ill-advised and its results unfortunate, it seems to me that we must not drift along using "biliary drainage" simply because it is being done, but as scientific physicians we must stop for a few minutes to see how much grounding it has in physiologic fact, and how much likelihood there is of its ever being able to clear up the diseased conditions which we find in cholecystitis.

A review of the large literature which has already grown up about the subject shows that, for the most part, the clinical reports are very favorable. That is to be expected with any new form of treatment. On the other hand, nearly all the reports on work done in an attempt to determine the accuracy of Meltzer and Lyon's physiological contentions have served to cast doubt

upon them and upon the method derived from them. In the first place, Meltzer's original theorem of a contrary action has been pretty thoroughly discredited by the finding that a number of substances besides magnesium sulphate will produce the typical flow when they are injected into the duodenum. As most of these drugs do not relax the sphincter, it cannot be argued that they will reflexly stimulate the gall bladder. Furthermore, it cannot be shown on either animals or men that the flow of bile produced by magnesium sulphate is accompanied by a contraction of the gall bladder. It seems clear now that that organ is a weak and sluggish one which never contracts down like the urinary bladder does, even when it is stimulated directly by strong electric currents. When it does contract it produces pressures of at most 30 mm. of water, barely enough to overcome the resistance of the valves in the cystic duct. The writer has tried several times to stimulate the gall bladders of animals (anesthetized with urethane and opened under salt solution) into visible activity, but without success. We know also that at operations on men or on animals, the gall bladder is practically never found empty, as it would be if it occasionally squeezed out its contents. The available evidence suggests strongly that bile flows from the gall bladder, not because the muscle there has contracted, but simply because the pressure in the common duct has been lowered by the relaxation of the sphincter at the duodenal end.

Certainly, in the face of these physiological data, the users of the Meltzer-Lyon technic can no longer assume with any confidence that the dark bile comes from the gall bladder. There are a few experiments recorded which suggest that occasionally that may be the case, but most of them show conclusively that the color changes can be obtained in the entire absence of a gall bladder, that is, when that organ has been removed by operation or closed off by disease. It follows that if we cannot safely assume that the dark bile has come from the gall bladder we must not attempt to diagnose cholecystitis because we find bacteria or detritus in that bile. Furthermore, it must be remembered that although the duodenum contains fewer bacteria than does any other part of the bowel, it generally contains some; and it has been shown that an increase in their number will depend largely on the degree of acidity of the gastric juice, upon the amount of saliva swallowed, the sterility of the last food eaten, the condition of the teeth, etc. Another difficulty is that in a surprisingly large proportion of cases of gall bladder disease operated upon, no bacteria can be grown from the bile even with the most advanced cultural methods. Even in the presence of stones, more than 50 per cent of the biles are sterile. Unfortunately, few of the men who have tried to use the Meltzer-Lyon technic diagnostically seem to have been aware of these limitations and sources of error.

THERAPEUTIC PROBLEMS

It seems pretty clear from this review that as a diagnostic procedure the method has hardly a leg to stand upon. Let us see now if it fares any

* Read before the Section on General Medicine at the Fifty-first Annual Meeting of the Medical Society of the State of California, Yosemite Valley, May, 1922.

better when we come to examine its therapeutic pretensions. To begin with, we can admit two things: First, that it cannot be expected to have any influence on gall stones; second, that it may easily be of some benefit in the treatment of catarrhal jaundice. Even there, however, it is hard to say how much good it does because the patients get well anyhow, and one can never tell in a given case whether or not the period of illness has been shortened by the treatment. Thus, recently, one of my patients began to fade in about three days. If I had done as I had planned, and had given him one or two Meltzer-Lyon treatments, the outcome in his case would have furnished a strong argument in favor of the new technic.

The great difficulty in treating chronic cholecystitis is that we are faced with an infectious process which is localized not only in the walls of the gall bladder but, as Graham and Judd have shown, is generally scattered through the liver, through the glands about the cystic duct and often into the head of the pancreas. Even if we could clear up this infection with a few treatments, how could we hope to prevent its recurrence; and why should we expect a "non-surgical drainage" to succeed when the surgical drainage has so often failed? As is well known, a large proportion of the people who are relieved of their symptoms after operative drainage, return later for a cholecystectomy, because the infection has returned and new stones have been formed. Meyer, at the Hooper Foundation, has produced chronic recurring cholecystitis in animals simply by putting small foreign bodies into their gall bladders. This little handicap so lowers the resistance of the organ that although it may clear itself of the infection from time to time, it cannot remain clear. Similarly, a woman with gall stones or a scarred gall bladder, is subject to a flareup of infection whenever she has a cold, or whenever she puts undue strain on her digestive tract.

That being the case, it seems to me that there is only one thing to do with a chronically diseased gall bladder if we really want a cure, and that is to take it out. Individual cases will always have to be treated individually, however, and in the present state of our knowledge it is often hard to decide when a patient should be urged to go to the surgeon, and when she should be advised to let well enough alone.

I am glad to see that Lyon now admits that we must be careful how we speak of "cures" in an essentially chronic disease, and that he advises immediate operation in many of the bad cases. I agree with him that his technic is worth trying on certain people who for one reason or another cannot submit to operation, or who have had unsuccessful or partly successful operations. Furthermore, I think it should be tried in every rebellious case of catarrhal jaundice. The method may occasionally be helpful in establishing the presence of severe cholecystitis, but I would never think of relying upon it for the diagnosis of early or obscure forms of the disease.

LETHARGIC ENCEPHALITIS

By N. T. McARTHUR, M. D., Napa State Hospital, Imola, California

Epidemic Encephalitis began in Europe in 1916 and 1917, following in the wake of the influenza. Early the next winter the disease appeared in epidemic form in Paris. It then spread to England, where it was mistaken for Botulism, but the error was soon corrected by the investigation of McNalty, James and Marinesco and McIntosh. Encephalitis did not remain in Europe, but soon spread to Africa, Asia, Australasia and America, appearing here in the winter of 1918 and 1919.

It is interesting to note the spread of Encephalitis in America during the first six months of 1921. In New York there were 153 cases; in Connecticut 52; in Illinois 168; in Wisconsin 16; in Oregon 11; in California 30. The southeastern, southern and southwestern states seemed to have escaped, as only a few scattering cases were reported. The disease first made its appearance in Napa County the latter part of September and continued until the middle of October, claiming in Napa alone five patients, all of whom died. The disease met with at Napa was of a very virulent and rapid form, being of three distinct types: lethargic encephalitis, poliomyelitis and a milder type of encephalitis with a crisis and a rather rapid convalescence.

Age and Sex—There were five cases in all, the youngest patient being five years old and the oldest eighteen; two males and three females.

Relation to Influenza—This relation was direct; in all cases there was a history of influenza.

Mode of Onset—The premonitory symptoms were lassitude, general malaise, marked constipation, insomnia, pain in neck, jerking and twitching being frequent symptoms, with headache and gastro-intestinal disturbances culminating in vomiting.

Fever—All patients had fever, the temperature rapidly rising from normal to 105, with a slight drop before death.

Pulse—The pulse presented the usual features of infectious diseases, ranging from 100 to 120. At times the pulse was very weak and stimulation had to be resorted to.

Central Nervous System—Restlessness and insomnia were marked in all cases, especially the lethargic type which later developed listlessness, stupor, and a mask-like face. There were also present ptosis, diplopia, facial palsy, and partial opisthotonos with a characteristic pill-rolling posture of the hands. The patients remained in the state of lethargy and somnolence with a gradual darkening of the sensorium until pulmonary oedema caused death.

Cranial Nerves—Involvement of the third cranial nerve was shown by diplopia, also by ptosis which was present in three out of five cases. Involvement of fourth cranial nerve was shown by paralysis in three cases. Involvement of fifth cranial nerve was shown by difficulty in mastication in four cases. Involvement of the seventh cranial nerve was shown by incomplete facial palsy

in four out of five cases. Involvement of the ninth cranial nerve was shown by dysphagia in four out of five cases.

Peripheral Nerves—Involvement of the peripheral nerves was marked by pain, especially in the occipital region and in the nerves radiating from the spine. The patients also complained of pain along the various peripheral nerves in the upper and lower extremities. This pain at first was of a lancinating nature.

Trophic and Vasomotor Disturbances—There was always more or less cyanosis around the patient's finger tips and toes with profuse perspiration.

CASE REPORTS

History of Case 1—The patient was a well nourished male thirteen years of age, a native of California. He had a moderately severe attack of influenza in 1918. The present illness began October 2, 1922, when he complained of headache, general malaise, and marked constipation. On this day he vomited. His temperature was 102. He was rather talkative with marked insomnia. October 4 patient complained of headache, temperature 102.2. Physical examination was negative. In the evening the headache was more severe. The pupils were moderately dilated, reacting sluggishly to light. The patient was restless, irritable, and slightly delirious. The patellar reflexes were diminished. Kernig's sign was positive on left side; Babinski reaction was negative. The leucocytic count was 12,000. Temperature was 103; pulse, 112. October 5 the patient was restless with twitching of muscles, and was delirious throughout the night; temperature was 104; pulse 120; a marked stiffness of the neck with partial opisthotonos; diplopia present; ptosis and Kernig's sign marked on left, doubtful on right. Examination of chest was negative. Deep abdominal reflexes lost. In the evening his face assumed the expressionless type; at 5:30 p. m. his temperature arose to 105.2 with involuntary urination. October 6 Cheyne-Stokes' respiration during the night. Stupor manifest, but could be aroused to swallow nourishment; condition remained the same during the day, temperature slowly dropping; at 12 p. m. it was 101.8. October 7 dysphagia first noticed; other conditions the same. At 1:15 the temperature was slightly elevated; pulmonary oedema was marked; died at 2:25 p. m. (No autopsy was performed.)

History of Case 2—A well nourished female, aged 18, native of California, attended school, definite history of influenza in 1918. The family history was similar to that of "Case 1." Previous history: Had always been a very nervous girl subject to severe headaches and uterine pains at menstrual periods.

Present Illness—Patient has had a headache and uterine pains for the last three or four days; because she was in the menstrual period the pain was attributed to that. In the afternoon of October 9 she first learned of the death of her nephew, "Case 1," and had an hysterical laughing attack. Shortly afterwards her physician was called. Temperature 102; pupils wide and dilated, not reacting to light; complained of severe headache and pain in back and neck. October 10 temperature throughout the night varied between 102 and 102.4; marked constipation with insomnia. Examination of chest and abdomen, negative. Patellar reflexes normal; Kernig's and Babinski reactions negative. In the evening pain extended down the spine and was of a lancinating nature. Pupils as above; temperature rose to 103.4. October 11 pain extending down into legs; temperature 103; pulse 120; well marked double Kernig; Babinski negative; could not move the left leg; paralysis of a flaccid

nature. Patellar reflexes absent on left, present on right; no ankle clonus. Plantar reflexes diminished on both sides. Kernig's sign present on both sides; neck stiff and painful. Leucocytes 9000. October 12 during the night the temperature dropped to 99, then rose to 103 and dropped to 103 and dropped again to 100; marked muscular twitching with loss of deep abdominal reflexes; some retraction of head; very little pain; patient hopeful with a feeling of well-being. Her pupils remained as above; urinary retention. At 12 o'clock Cheyne-Stokes' respiration with marked cyanosis of face and neck. At 3:40 p. m. spinal puncture was done. Fluid was crystal clear and under no pressure. The cell count showed 80 large mononuclear cells; Globulin, negative; mastic and guinea pig inoculation. The left arm developed a flaccid paralysis with beginning paralysis of respiratory muscles; diaphragmatic breathing with slight opisthotonos; temperature 100; pulse rapid and weak; respiration, difficult; difficulty in swallowing. October 13 temperature still dropping; respiratory rate increasing; dysphagia with retention of urine; commencement of pulmonary oedema; profuse perspiration; mind clear and alert throughout illness; slowly sinking from respiratory paralysis; increasing pulmonary oedema; and death at 6 p. m.

Autopsy Report—Well built, well nourished female; age 18; pupils moderately dilated and equal; beginning rigor mortis of upper extremities. Brain: Marked infiltration and congestion of the vessels in the meninges; marked congestion of cortex and medulla showing a hyperaemia and a moderate exudate, particularly in the region of pons and medulla. Cut section of the brain showed marked punctate hemorrhages below the level of the fourth ventricle especially around the nuclei and extending out into the cortical portion of the brain. See Plate 3. Microscopical section of cerebellum showed perivascular infiltration.

Spinal Cord—Microscopical section of cord showed infiltration along the vessels parallel to the right dorsal horn of cord. Marked inflammation and round-celled infiltration were present about the vessels of the ventral fissure, also inflammation and round-celled infiltration about the vessels of the apex of the left ventral horn.

History of Case 3—A poorly nourished male aged ten, native of California, had a moderately severe attack of influenza in 1918. Present illness began October 3; complained of headache, general malaise, marked constipation with insomnia. October 4: Pulse 160; temperature 105.2; pulse rapid and weak. Patient restless, acts as if in pain, turning constantly with profuse sweating; unable to swallow; involuntary urine with ptosis, diplopia; face assuming mask-like character with arms in partial flexion and the fingers of the hand in characteristic pill-rolling posture. October 5: Patient complained of pain in head when roused from stupor, gradually growing into a more stuporous condition; difficulty in respiration; temperature the same; pulse 120, weak and thready. October 6: Patient in stuporous condition from which it was difficult to arouse him; commencing pulmonary oedema and death at 5 a. m. No autopsy.

History of Case 4—Poorly nourished male aged eight, native of California, attending school, direct history of influenza, brother of "Case 1." Present illness began October 4 with general malaise, marked constipation, talkative, with insomnia. October 5: pulse rapid, temperature 104.2; patient restless, complaining of pain in back of head in occipital region, neck muscles rather stiff and rigid. October 6: Patient very restless, temperature rising, with profuse sweating; difficulty in swallowing, involuntary urine with ptosis and diplopia; face assuming a mask-like character with arms and forearms as in "Case 3." October 7: Child growing into a more stuporous condition; difficulty in respiration; pulse 118, weak and thready. October 8: Patient in stu-

porous condition from which it was difficult to arouse him; commencing pulmonary oedema followed by death.

Autopsy Report—Poorly nourished male. Pupils moderately dilated and equal; marked cyanosis of face and neck. Beginning post-mortem rigidity. Post-mortem lividity from shoulders to buttocks. Brain: There was a marked infiltration of the vessels of the meninges with hyperaemia of the cortical vessels and a grayish exudate in the region of pons medulla. Cut section of the brain showed many punctate hemorrhages, especially around the substantia nigra. The cord, normal. Lungs, pulmonary oedema. Heart, cloudy swelling. Kidneys, cloudy swelling. Spleen, cloudy swelling. Liver, cloudy swelling.

Laboratory Findings of "Case 4"—Spinal puncture done on this case; fluid crystal clear; cell

stantly moving hands and feet. Eyes showed converging strabismus. Nasal passages, negative. Chest, negative. Abdomen, negative. Upper and lower extremities, negative. Skin dry and warm. Reflexes: Eyes react normally; knee-jerks exaggerated; Kernig sign positive; Babinski reaction positive; slight ankle clonus; cremasterics slightly increased; temperature 102.5; pulse 110; respiration 24.

September 26, some retraction of head but no definite opisthotonos, pain in neck and spine increasing. Spinal puncture taken and fluid crystal clear under slight pressure. Cell count, 18. September 22, spinal puncture seemed to have relieved patient, who was greatly improved; temperature had fallen to normal; respiration 18; pulse 100. The nervousness was replaced by apathy. There was no diplopia noted throughout illness. The reflexes

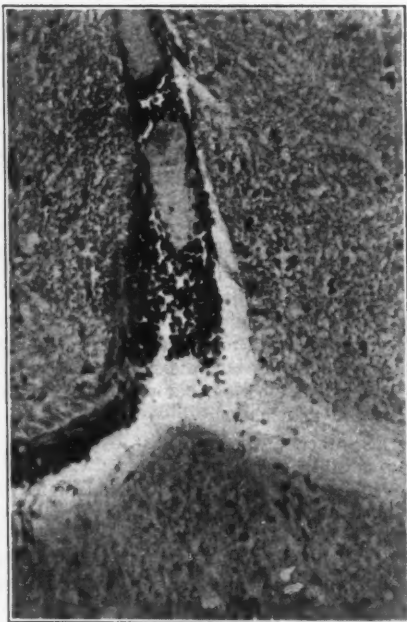


PLATE 2

Inflammation about vessel in brain. Obj. A (Zeiss) Oc.

count 3; globulin negative; colloidal gold, negative; mastic, negative; Guinea pig inoculation, negative. "Case No. 2" and "Case No. 4" had cultures taken from the ventricles of the brain and heart and inoculated on blood serum, bouillon and slant Agar, with negative findings.

History of Case 5—Poorly nourished female aged five, native of California, direct history of influenza. Present illness began October 4; died October 8. This case began with general malaise, headache, marked constipation, rapid rise in temperature with rapid, weak, thready pulse; developing stiffness in muscles of neck, diplopia, ptosis, irritability, stupor, delirium, mask-like face, pulmonary oedema, and death.

History of Case 6—Male, aged twelve, native of California; family history negative. Previous history, measles, mumps, scarlet fever. Present illness, September 25, patient had some fever, causing the mother to suspect a gastrointestinal upset. The following day he went to school, complaining of headache and fever; pain over the cervical and upper thoracic vertebra. Physical examination: Fairly well-nourished boy of twelve; restless, con-



PLATE 3

Showing punctate hemorrhage and dilatation of vessels throughout the gray and white matter below the level of the third ventricle.

were markedly diminished. There were no sensory disturbances except along the spine, which was markedly hypersensitive. The forearms were flexed across the chest, and attempts at forcible extension were very painful. For the following forty-eight hours there was no change. The patient slept most of the time, after which the drowsiness began to diminish and he made a rapid convalescence. A week later, patient was convalescing satisfactorily. There was no evidence of paralysis; reflexes negative; forearms could be extended nearly 90 degrees; mentally clear.

Epidemic Encephalitis belongs to the class of infectious diseases of an inflammatory nature. Rosenau has demonstrated that the filterable virus reproduces the disease in white rabbits. The six cases presented in this paper show three distinct types: Cases 1, 3, 4 and 5 are distinctly lethargic in nature and of a very rapid, virulent form. Case 2 falls in the Poli-encephalitis type, while Case 6 is of a milder lethargic type, progressing

after the acute symptoms to a successful convalescence and to a recovery. Most authors claim no contagion or infection; however, here we see a whole family dying, one child after another. Case 1 attended the same school as Cases 3, 4, 5 and 6. Case 2 was the aunt of Case 1, and had been indirectly exposed to Case 1. Therefore, the question of the mode of transmission appears to be rather direct in this family. For the differential diagnoses from the laboratory standpoint, see the following table:

Condition	Color	Globulin	Cells	Lange	Mastic
Normal	Clear	Negative	1 to 5	Negative	Negative
Encephalitis	"	"	10 to 20	"	"
Menin- gococcus	Turbid	Positive	50 to 800	Menin- gitic zone	Positive
Ant Polio- myelitis	Opa- lescent	"	10 to 100	Luetic zone	"

Pathology—The cerebral cortex was found normal except for congestion of the vessels of the meninges (See Plate 1). In the brain substance the changes were more marked in the basilar nuclei of the brain, the upper part of the pons and peduncles and in the gray matter around the floor of the fourth ventricle (See Plates 3, 4 and 5). Negative findings in the cord except in Case 1, where the cord was more or less involved during its entire length. The meninges showed hyperaemia, distention of the vessels with small punctate hemorrhages.

Microscopic—The pia of the cerebrum and cerebellum showed distention of the vessels with blood, round-celled infiltration especially marked around and in the vessel walls. Very slight perivascular infiltration in the brain substance; here and there a hemorrhage is seen in the outer vessels of the cortex. In the medulla, pons, basal ganglion. The pia showed the same pathology, but more marked and the perivascular infiltration follows the vessels deeply into the tissue; cellular infiltration is found both in the white and gray matter but by far the greater per cent is in the gray matter. The cells are mostly lymphocytes, plasma cells, and a few large mononuclear cells. The blood-vessels, though densely infiltrated, showed no endarteritis.

CONCLUSIONS

The pathological pictures showed typical round-celled infiltration with perivascular inflammation, Case 2 showing a marked similarity to poliomyelitis, but such extensive infiltration of the meninges and larger vessels of brain would be unusual in poliomyelitis. A direct relation between influenza and encephalitis was proved in all cases except in that of Case 6. Cases 1, 2, 3, 4 and 5 would rather lead us to suspect that encephalitis is an infectious disease.

I wish to thank doctors E. Z. Hennessey, Robert Cress and C. H. Bulson of Napa for the case histories of these patients; Dr. A. C. Matthews, Medical Superintendent of the Napa State Hospital, for allowing me the time to do this work; and Dr. Frank E. Blaisdell, Sr., and Dr. William Ophuls of the Stanford Medical Department for taking the photographs and for their suggestions.

CHAIRMAN'S ADDRESS, EYE, EAR, NOSE AND THROAT SECTION *

By F. A. BURTON, M. D., San Diego

First of all I wish to thank Dr. Harvard McNaught, the secretary, and the members of the section who have co-operated in providing the program for the meeting. With this valuable assistance, the work of the chairman has been a pleasant task. Since our time is limited, I will confine myself to a few general remarks.

There are three classes of eye, ear, nose and throat specialists—the progressive, the stationary and the retrogressive. The retrogressive has passed the period of usefulness; the stationary is the one who says in his heart, "My work is good enough"; the progressive is the specialist who forges ahead. It is not necessary that one go forward by leaps and bounds, but the essential point is that he is moving in the right direction.

It is a well known fact that every religious, political or educational system is judged by the kind of man it forms. This also holds true of a medical society—with this difference: that the latter is more democratic. As the people of a democratic government are the government, so the members of a medical society are the society, and it is up to the individual member to decide the nature and value of his organization. We get out of life just what we put into it, and you will get out of this section meeting just what you put into it. If you are satisfied to listen to the reading and discussion of papers by others, you will get something out of the meeting, but you will get infinitely more if you take part.

In his practice the specialist of the first class makes careful, thorough histories; he goes back at least to the history of the immediate family, and the patient's history of disease is taken from birth to the time of examination. Wherever possible, it is valuable to obtain the information of when, where and how the first symptom relevant to the disease in question made its appearance. It is not enough to learn only the symptoms presenting at the time of the examination.

The progressive eye, ear, nose and throat specialist continually reviews the anatomy of his field. This is especially needful in investigating the nasal accessory sinuses, because of their anatomical variance. In addition to the usual methods, transillumination and the X-ray are employed. The X-ray may not be necessary to determine a sinus infection, but it is valuable in ascertaining the size, shape and extent of the cells. No sinus surgery should be performed without first determining these important points. The progressive specialist in this field looks for pathology. It is not scientific, upon hearing the symptoms, to jump at a final conclusion as to the diagnosis. In determining the pathology causing the symptoms, a complete physical examination is often required, as it is important that the most urgent thing receive attention first. In case of infection, it is of

* Read before the Fifty-first Annual Meeting of the Medical Society of the State of California, Yosemite Valley, May, 1922.

undoubted value to know the bacteriology. If due to streptococci, the condition is more serious than if due to staphylococci, and if the intruding germ be the streptococcus haemolyticus, rapidity of action and probability of extension must be taken into account. And if the infecting organism be the streptococcus mucosus capsulatus, one looks for extensive destruction of both soft and bony tissue, even in the absence of pain.

The progressive specialist, in his surgical cases, gives careful attention to the matter of anaesthesia. He considers the welfare of the patient and is not a slave to routine. In his intranasal and sinus surgery, whenever possible, he uses local anaesthesia.

The specialist of the first class avoids unnecessary surgery through conservative medical treatment; where surgery is necessary, through thorough examination and pre-operative care, he lowers the surgical risk. He provides wherever feasible a field free from pus and inflammation. Subsequent to the operation he administers the indicated post-operative care until the wound is healed. In this way he observes the final outcome of his work, renders a valuable service to his patient, and adds to his own satisfaction. The specialist who is moving in the right direction, has the welfare of his patient, his society, and his fellow physician sincerely at heart.

You share in the responsibility of failure on the part of your medical society, your hospital, or your fellow in medicine to comply with the highest requirements. Such a failure calls for calm and constructive criticism. Boost, don't knock. You cannot despise, envy or hate another without giving him some of your time. Be leaders, not followers. A man is not made by what others think of him, but by what he thinks himself. Merit a good opinion of yourself.

He who has climbed can lift, and you have reached an enviable height among eye, ear, nose and throat specialists. Others are influenced by what you do. You have accepted the exalted position of leadership. Let your relations with patients be free from mystery, and with referring physicians, free from secrecy. Your patient has the inalienable right to human interest and scientific service.

Remember with Lord Essex: "Genius is entitled to respect only when it promotes the peace and improves the happiness of mankind."

Resolution Approving Women's Auxiliary—"The Women's Auxiliary of the State Medical Association of Texas respectfully requests the approval of the American Medical Association of a movement to organize a Women's Auxiliary to the American Medical Association. The object of this auxiliary shall be: To extend the aims of the medical profession through the wives of the doctors to the various women's organizations, which look to the advancement in health and education; also to assist in entertainment at all Medical Conventions, and to promote acquaintanceship among doctors' families that closer professional fellowship may exist."—Abstract from Minutes of the Seventy-Third Annual Session of the A. M. A.

CHAIRMAN'S ADDRESS, SURGICAL SECTION *

By CHAS. D. LOCKWOOD, A. B., M. D., F. A. C. S.

Members of the Surgical Section:—

I am deeply appreciative of the honor you conferred upon me one year ago in electing me chairman of this section. Although this is but the third year that we have met as an independent section, there is already apparent a spirit of loyalty and co-operation which augurs well for the future growth and scientific character of our meetings.

The field of the general surgeon is being ever more and more narrowed by the growth of specialism. Surgeons of the generation that is now passing have regarded as their domain the entire field of surgery, with the possible exception of eye, ear, nose and throat work. The surgical specialists have gradually emerged as our knowledge of technique and diagnosis broadened. The older specialists were the natural outgrowth of their environment and practice. Well grounded in the principles of surgery, they readily acquired the technique of new operations and kept abreast of all new developments in surgery. Chance, special adaptation or the exigencies of practice were the deciding factors in the selection of a specialty more often than deliberate choice.

This older type of specialism was founded upon a broader surgical experience and a deeper knowledge of human nature, but it lacked in the diagnostic skill and refinement of technique which characterize the specialists of today. The newer generation of specialists have, for the most part, deliberately chosen their field of work and have acquired great skill in the use of the newer instruments of precision and familiarity with the laboratory and other methods of diagnosis. Too often this special skill has been acquired at the sacrifice of a broader and more fundamental knowledge based upon practical experience.

It is no longer possible for any one individual to cover the whole field of medicine and surgery and it is inevitable that specialism will flourish ever more and more. There is, however, grave danger that this tendency toward specialism will lead to professional suicide. Regular schools of medicine have become so highly specialized and exclusive that they no longer qualify men for general practice. The vast majority of recent graduates are ambitious to become specialists and few of them are willing to travel the more difficult path of the general practitioner. Our line of communication or contact with the average sick person is being broken and the place of the old-fashioned family physician is being usurped to a certain extent by the chiropractors, the osteopaths and other cultists.

Many people cannot afford to pay specialists' fees and they are unwilling to do so when they have only what they believe to be simple ailments. There should be some way provided whereby the best in medicine and surgery will be avail-

* Read before the Fifty-first Annual Meeting of the Medical Society of the State of California, Yosemite Valley, May, 1922.

able for the average citizen. This need is being met in a fairly satisfactory way for the poor man by free clinics and dispensaries, but it is more difficult for the self-respecting person of moderate means to secure the best that scientific medicine has to offer. This large class patronizes extensively the faddist and the pseudo-doctor of the day. It is to this class that we must look for support in our efforts to promote public health. They must have more of the benefits of scientific medicine than they can afford to pay for at current fees of hospitals, laboratories and specialists. There are two or three possible solutions of this problem.

The organization by physicians of health centers, accessible to citizens, country districts and smaller towns. These centers must be under the control of the medical profession, either through their county societies or by other means of co-operation between medical men. They should be manned by a corps of physicians representing the various specialties, nurses trained in public health work and technicians in laboratory and X-ray work. Patients too sick to visit these centers should be cared for in community hospitals, conveniently located and under the direction of the personnel of the health center. Contact should be maintained with convalescent patients and those only mildly sick through visiting nurses and younger physicians who are serving an apprenticeship before entering upon a specialty. A schedule of fees commensurate with the ability of the patient to pay should be maintained and a fair distribution of this compensation made among those serving the center.

Group clinics, organized by physicians and conducted as private enterprises. The fundamental object in every such organization must be better service to the sick. Co-operation is most essential in diagnostic work. Not only is proximity of offices desirable, but there must be congeniality, mutual respect and a high sense of responsibility on the part of each member of the group. There should be perfect freedom in referring patients to the various departments and frequent group conferences should be held on obscure and difficult cases.

The aids to diagnosis have become so numerous and complex that little or no profit can be expected to accrue from the diagnostic side of medicine. It is possible, however, to greatly reduce the cost of complete examinations by co-ordinated effort and to bring it within the reach of those of average incomes.

The third method by which complete and satisfactory medical and surgical service may be rendered is through a well organized hospital having a closed staff. If it is to serve all classes of patients and give them the benefit of group diagnosis, it must have a large endowment and a resident staff. Such institutions are possible only in our larger cities or connected with teaching institutions.

What shall be the role of the general surgeon in this new era of medicine which seems to be dawning? Is his field to become so restricted by the encroachments of the various specialists that he himself will be compelled to limit himself to

one organ or one group of organs? Is he to share equally with the internist the growing field of diagnosis or is he to degenerate into a repair man who will be called in to patch a blowout or remove a defective spark plug?

The field of diagnosis has heretofore been surrendered largely to the internist and the surgeon has been content to concentrate upon technique. There is no good reason why this should be so. The qualities of mind and the manual dexterity which distinguish the modern surgeon also qualify him for the work of a diagnostician. With a broad general training, his special knowledge of anatomy and his familiarity with living pathology, he should be ideally equipped to compete with the physician in the field of diagnosis. There should be no line of demarcation between surgical diagnosis and general diagnosis.

The physician and the general surgeon aided by the laboratory and other special diagnostic facilities, should work hand in hand maintaining a broad outlook upon the whole field of medicine and acting as balance wheels for the more restricted specialties.

Educating the People—"To give the people such a general knowledge of medicine that they will appreciate the importance of methods for the prevention of disease, will appreciate the advantages of early diagnosis and treatment of beginning maladies, and know something of the nature of the diseases with which they are or are likely to be afflicted, but particularly that they will be less credulous in accepting the claims of uneducated and untrained dabblers at the healing art, is an undertaking of no small magnitude. One naturally wonders how it is to be accomplished and who is to accomplish it. That the medical profession, the nursing profession, and the Public Health Service are now rather promiscuously engaged in the undertaking does not assure us that it will be accomplished by either or all of them.

When the family physician was in vogue, his people entrusted the care of their health and their lives to one in whom they had confidence, whose word they accepted without question, whose advice they followed without reservation. They had no desire for intimate knowledge of disease processes and saw no occasion to investigate the relative value of different methods of treatment. There are still a few of these people in the world. There were many others not thus attached; some with a little wisdom, more conceit and no confidence in anyone; some with no wisdom, no conceit and confidence in everyone; but all complaisant dupes to the ingenious tyro, smooth-tongued charlatan, and patent medicine venders. There are still many of these people in the world. Men in the medical profession bewail the credulity of the people in things medical, but of all the people in the world the most credulous in things not medical are the men in the medical profession."—(The Journal of the Kansas Medical Society, June, 1922.)

Resolution Directing a Survey of Pay Clinics and Group Practice—(Abstract from Minutes of the Seventy-Third Annual Session of the A. M. A.)

"(d) Your committee approves the recommendations of the Board of Trustees that a survey be made of existing pay clinics, diagnostic clinics and group practice, to be conducted jointly by the Judicial Council and the Council on Medical Education and Hospitals. We recommend that their reports and recommendations be submitted to the next annual meeting of the house."

AN ANATOMICAL AND EMBRYOLOGICAL STUDY OF THE PERINEUM *

By MILEY B. WESSON, M. D., San Francisco

INTRODUCTION

The foundation of all perineal surgery is an exact knowledge of the rectourethralis muscle and Devonvilliers fascia. The information gained from a perusal of the literature is unsatisfactory, as the nomenclature is confusing, and the descriptions vary markedly, being based upon studies of individual variations. The exact origin and insertion of the rectourethralis muscle is most important, since, aside from the loss of urinary control caused by cutting the external vesical sphincter, the only valid objection urged against the perineal prostatectomy is the danger of a rectal tear due to the improper dividing of this muscle. Devonvilliers fascia is the goal aimed for in every perineal operation, and when its glistening white layer comes

seminal vesicles, vasa-deferentia and inferior extremities of the ureters.

In 1899 Cuneo and Veau went a step further and stated that the prostato-peritonele aponeurosis of Devonvilliers was formed by a fusion of the fetal peritoneum of the rectovesical cul-de-sac, the two peritoneal layers combining and forming an aponeurotic sheet with a complete correspondence of the arrangement of the peritoneum in embryos of both sexes. Even if the original fused layers disappear they make the framework for later layers of fibers. As proof of this primitive fusion they call attention to evidences of incomplete fusions such as vesico-seminal cysts, perineal hernias and the cul-de-sac of Douglas in the female.

The following year Proust stated that, while the ideal scheme was to admit the existence of a pre-rectal fascia forming a nucleus of the perineum, as suggested by Devonvilliers, unfortunately the hypothesis could not be reconciled with surgical anatomy, for while it was easy to separate the coverings of the prostate into anterior and posterior layers, it was most difficult to peel out the seminal vesicles, bladder and rectum.

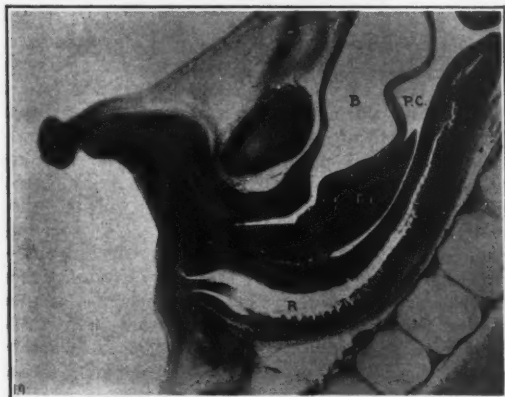


Fig. 1.—Mid-sagittal section of genito-urinary region of 46 mm. human embryo. The fused layers of fetal peritoneum have not been wholly absorbed, as is shown by the presence of small "cysts"; S, symphysis; B, bladder; PC, peritoneal cavity; ED, ejaculatory duct; R, rectum. (Embryo, Carnegie Institute, 1686, slide 23, row 1, section 2.) X 21.

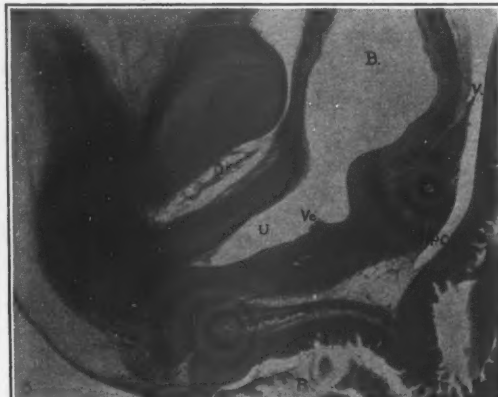


Fig. 2.—Sagittal section through pelvis of 67 mm. human embryo: B, bladder; U, urethra; Ve, verumontanum; V, vas deferens; SV, seminal vesicle; P, prostate; PC, peritoneal cavity; R, rectum; RU, rectourethralis muscle; CC, corpus cavernosus; S, symphysis pubis. (Embryo, Carnegie Institute, 1686, slide 47.) X 18.5.

into view the surgeon feels that he has passed the region of uncharted dangers. This fascia, which separates the rectum from the prostate, can be split into two layers, and hence the didactic statement, that it represents the fused layer of the fetal peritoneum, has been generally accepted.

HISTORY

Devonvilliers, in 1836, enunciated the hypothesis that the center or nucleus of the perineum is a pre-rectal raphe or "aponeurosis prostato-peritonele." This fibrous plane is triangular in shape with a truncated apex deep behind which blends with the superior layer of the triangular ligament, while the base at the top is adherent to the inferior face of the peritoneum, thereby helping form the rectovesical cul-de-sac. The posterior layer is in contact with the rectum to which it is joined with very loose cellular tissue, while from the superior face arise dense cellular elongations which envelop the

MATERIAL AND METHODS

The material used for microscopic study consisted of serial sections of 31 human embryos obtained from the collection of the Carnegie Institute of Embryology. Several specimens of the rectourethralis muscle were obtained at operation, sectioned and stained with differential stains. The microscopic investigations consisted of dissections of both preserved and fresh cadavers of infants and adults. A glass model was constructed of the pelvis of a seven months fetus, cut transversely in sections 100 microns thick. An Edinger projection apparatus was used, and the sections traced directly on 8x10" glass plates by means of various colored Higgins inks. Distortion of the model was prevented by keeping the magnification in proportion to the thickness of the sections. The glass plates were then stacked, divided into packs about two inches thick and bound firmly with adhesive plaster. When mounted in a frame, with electric lights behind them, they appeared as colored gela-

* Read before the Section on Urology at the Fifty-first Annual Meeting of the Medical Society of the State of California, Yosemite Valley, May, 1922.

tin molds in a glass case. A preparation of this kind is far superior to a wax model for perineal studies, as it gives a transparent presentation of an entire region, which in this model shows ten structures and their relationships, instead of an opaque representation of a single organ.

EMBRYOLOGY OF THE PERINEUM

The primitive pelvis is divided into a ventral and dorsal half by the fusion of the two urogenital folds which unite throughout their whole length in the median line. This frontal partition is termed the genital cord and appears in embryos between 19.4 and 20 mm. It was formerly believed that sexual differences appeared with the formation of the genital cord, but Spaulding has recently shown that they are present from the be-

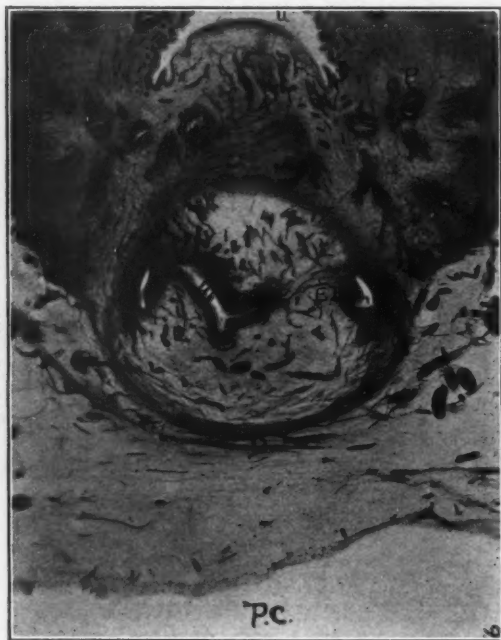


Fig. 3.—Transverse section through posterior urethra, distal to verumontanum, of 210 mm. human embryo. A dense fascia surrounds the utricle and ejaculatory ducts, separating them from the prostatic tissue: U, urethra; Ut, utricle; ED ejaculatory duct; P, prostate; PC, peritoneal cavity; D, Denonvillier's fascia. (Embryo, Carnegie Institute, 2402, slide 245, section 2.) X 18.5.

ginning. The rectovesical pouch which extends to the floor of the perineum in a 15.5 embryo reaches just below the level of the verumontum in a 46 mm. specimen (Fig. 1), and at 240 mm. reaches to the middle of the seminal vesicles. In many of the specimens studied the peritoneal pouch was asymmetrical, being slightly deeper on one side than the other.

When the peritoneal layers fuse, the mesothelium is absorbed and disappears, leaving only a bed of mesenchyme. In one 25 mm. embryo there was an apparent raphe as the absorption was not complete; in other specimens showing incomplete absorption the line of fusion was marked by iso-

lated portions simulating cysts—all lying closer to the rectum than to the prostate. In none of the older specimens, where differentiation is more complete, is there any evidence of the persistence of the fused peritoneal layers as a raphe or cysts (Fig. 2).

GROSS ANATOMY OF PELVIC FASCIA

Because of the confused nomenclature, a brief description of the gross anatomy of the pelvic fascia is necessary. This layer is a continuation of the transversalis fascia in front and the iliac fascia on the sides. It is made up of a primary parietal layer and a secondary visceral layer. The parietal layer forms a cylindrical membrane attached above and below to the inlet and outlet of the pelvis, forming the pyriformis fascia behind, the posterior layer of the triangular ligament in front, and laterally the obturator fascia and ischio-rectal fascia (or covering of the under surface of the levator ani muscle).

The visceral pelvic fascia is a membranous diaphragm separating the pelvic cavity above from the perineum below and covering the upper surface of the levator ani muscle. This fascia passing inward from the white line on either side forms the lateral ligaments of the bladder, and at the junction of the bladder and prostate it splits into two layers, one passing up around the bladder and the other down over the prostate. The former splits into two layers on either side of the midline to enclose each seminal vesicle and vas deferens, and then bending together continue forward over the bladder to the pubes forming the anterior true ligaments. From that portion of the fascia overlying the seminal vesicles and vasa deferentia arises the layer that forms the outer coat of the ejaculatory ducts and accompanies them through the prostate (Fig. 3).

The prostate has a capsule which consists of a comparatively thin layer of fibrous tissue and involuntary muscle fibers closely adherent to the gland and penetrating the substance. Being continuous with the glandular stroma, it cannot be separated from it without laceration of the gland tissue. It is analogous to the fibrous capsules of the liver and spleen.

The layer of fascia which passes down around the prostate forms a funnel-shaped sheath which is complete except for a vertical band on the anterior surface. Here, because of the extra strain placed on the pelvic floor, due to the upright posture of man, there has been a condensation of fascia and fibrous prolongations between sheath and capsule which unite them so firmly that it is impossible to separate them.

Devonvilliers fascia or the fascia between the prostate and the rectum consists of two layers, one covering the prostate and the other the rectum. These two layers meet above at the vesico-prostatic junction, where they both spring from that portion of the visceral fascia which may be said to stretch across the pelvis between the urogenital apparatus and the rectum. When the rectourethralis muscle is divided the incision should likewise divide the posterior or rectal layer of Devonvilliers fascia,

which is then pushed back with the rectum. Thus is formed the "espace decollable rectroprostatique" or separable space, and the anterior layer of Devonvilliers fascia or sheath of the prostate is exposed. The texture of this resistant membranous layer resembles the dartos, being made up of glistening fibrils most pronounced in the midline.

GROSS ANATOMY OF THE RECTOURETHRALIS MUSCLE

The rectourethralis muscle is of primary importance to the perineal surgeon since it is responsible for the acute anterior flexure of the rectum and the consequent approximation to the apex of the prostate (Fig. 4). A bundle of muscle fibers is sent to the coccyx from the posterior thickened longitudinal band of the rectum, thus forming the recto-coccygeus muscle; and a corresponding bundle arises anteriorly at the level of the verumontanum

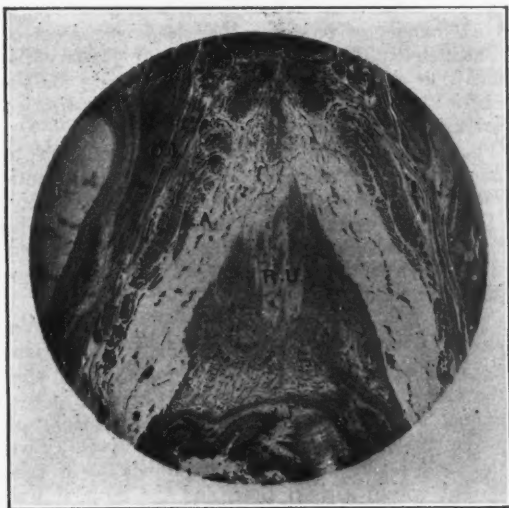


Fig. 4.—Transverse section through pelvis of 208 mm. human embryo, showing the relationship between the rectourethralis and levator ani muscles: RU, rectourethralis muscle; LA, levator ani muscle; OI, obturator internus muscle; I, ilium. (Embryo, Carnegie Institute, 2402, slide 261, section 1.) X 7.

and passes to the raphe of the external vesical sphincter, thereby forming the rectourethralis muscle (Fig. 5). This raphe fuses with the under side of the central tendon of the perineum, which lies about $2\frac{1}{2}$ cm. in front of the anus and is formed by an interdigitation of the fibers of the external anal sphincter, the transverse perineal and the bulbocavernosus muscles.

A study of the specimens of the rectourethralis muscle obtained at operation showed smooth muscle fibers at one end flowing into a bed of elastic tissue containing striated fibers at the other.

Contrary to the generally accepted view the levator ani muscle lies lateral to the prostate and is definitely separated from it, and sends no fibers over its posterior surface either directly or indirectly through the rectourethralis.

DISCUSSION

The fascia being merely condensations of connective tissue, have marked individual variations

in density. From the urological standpoint they are of interest not only as structural supports, but as protective partitions which guide the paths of extravasations of urine, infections and malignant growths. The perineum has a three-fold protection from extravasation of urine due to rupture of the anterior urethra, the first barrier being Bucks fascia, then Colles and lastly (the anterior layer of) Devonvilliers fascia. The latter is of primary importance in preventing cancer of the rectum spreading anteriorly and effectively confines early cancer of the prostate so that it can be entirely eradicated by means of the radical prostatectomy of Young.

Two anomalies of interest to the urologist were



Fig. 5.—Sagittal section through pelvis of adult, showing diagrammatically the relation existing between the external vesical sphincter (EVS) and the rectourethralis muscle (RU); if the dissection follows the posterior surface of this muscle the rectum will be opened, but if the muscle is cut at its junction with the external vesical sphincter the rectum will drop back and the prostate be exposed.

seen in the embryos studies. In the glass model of Embryo 2375 the testicles show in the inguinal canals, the right one being normal, but the left is rotated so that the globus minor lies above and the globus major below. Could not this be the forerunner of a torsion of the testicle?

Embryo 1656 has a long Cowpers duct, whose orifice is near the meatus. This is of particular interest since no adequate theory has yet been advanced to explain the origin of periurethral ducts. In an adult such a structure would undoubtedly be classified as such.

SUMMARY

1. Devonvilliers fascia is not formed by a fusion of the fetal pelvic peritoneal.
2. The rectum, at the level of the prostate, is surrounded by a more or less definite cuff of

connective tissue in which the lowest part of the peritoneal cavity dips.

3. At no stage of development is the peritoneum in contact with the prostate, it always being nearer to the rectum than to the prostate.

4. The recto-prostatic space is filled at first with a synticium or mass of embryonic connective tissue cells; eventually differentiation occurs and there is a condensation of connective tissue anteriorly and posteriorly. The anterior layer covering the prostate is the thicker and the elastic tissue fibrils predominate, thereby causing the shiny appearance characteristic of Devonvilliers fascia.

5. A sheath of fascia surrounds the ejaculatory ducts and utricle as they pass through the prostate.

6. The rectourethralis is a sheet of muscle arising from the external longitudinal layer of the rectum and ending in the raphe of the external vesical sphincter.

7. In exposing the prostate by the perineal route the rectourethralis muscle should be cut close to the central tendon, the incision being sufficiently deep to sever the posterior or rectal layer of Devonvilliers fascia, and the dissection continued anteriorly to the muscle, for if the posterior layer is followed it leads directly into the rectum. If the incision is made anterior to the central tendon the dissection leads first into the venous bulb, causing hemorrhage, and then through the external vesical sphincter. The opening of the rectum is avoided, but there is a prolonged and often permanent loss of vesical sphincter control.

8. Long Cowpers ducts ending near the meatus probably develop as periurethral ducts.

(549 Flood Building.)

Resolution on Medical Ethics—"Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these may be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. That does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession, and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physician, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

"It is unprofessional to promote radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of disease; or to employ any methods to gain the attention of the public for the purpose of obtaining patients."—Abstract from Minutes of the Seventy-Third Annual Session of the A. M. A.

EARLY HOSPITAL HISTORY IN THE UNITED STATES *

By J. B. CUTTER, M. D., Watsonville, Cal.

With universal interest rapidly growing in all parts of the United States, in the upbuilding and expansion of the modern hospital, the following contribution of historical data about hospitals seems timely.

It is probable that the first hospital in the United States was the Pennsylvania Hospital. There were earlier institutions in Canada and Mexico, and efforts were set on foot as early as 1709 to establish a hospital in Philadelphia. In 1730-31 the City Almshouse was founded, and did medical work, but it was not until 1750-51 that the Pennsylvania Hospital had its actual birth. A history of this hospital was published by Dr. Thomas G. Morton in 1895.

A number of physicians and leading citizens of Philadelphia presented a petition on January 23, 1751, to the Provincial Assembly, praying for authority and assistance to establish an institution for the care of "the insane and indigent sick." Dr. Thomas Bond and Benjamin Franklin seem to have been most active in working up public sentiment, and pushing the matter before the Assembly. The hospital was finally granted a charter by the Governor May 11, 1751. Joshua Crosby was the first president of the Board of Managers and Benjamin Franklin, the first clerk.

The charter of the Pennsylvania Hospital, after providing minutely for the government and management of the proposed institution, appropriated the sum of two thousand pounds to be paid in two annual installments, conditioned on the raising of a like amount through private contributions. Two thousand seven hundred fifty pounds were subscribed within a short time, and the hospital was organized.

The Board of Managers then petitioned Thomas and Richard Penn, who were then living in England, to donate a site for the hospital. This request after considerable correspondence was finally granted, but with so many restrictions that the board resolved not to accept the gift. As the need of the hospital was pressing, a temporary arrangement was entered into by which a private house was rented, and opened for patients February 6, 1762.

Negotiations were kept up with the Penns, which finally led to the purchase from them of part of the present site in 1754, and the remainder of the land was given to the hospital in 1767.

A suitable site having been obtained, plans were drawn and approved and the building begun. The cornerstone was laid May 28, 1755, and the building was so far completed by December 17, 1756, that patients were moved into it on that date from the temporary quarters.

In the meantime the first president, Joshua Crosby, died in June, 1755, and was succeeded by

* Read before the Santa Cruz County Medical Society, at its meeting held in Santa Cruz March 6, 1922.

Benjamin Franklin, who served until his appointment as Provincial Agent at London, in 1757.

This is an outline of the early history, as far as authority can be found, of the first hospital in the United States.

The New York Hospital was the second hospital of importance to be established in the United States. Its charter was granted in 1771.

The history of this second hospital is more clear, and its connection with Trinity church adds to its interest.

There is especial appropriateness in the linking of those two ancient New York institutions, for it was in Trinity church that the hospital was conceived, and through the church influence that it came into being. There is spiritual significance in the association of the church with the divinely appointed mission of a hospital at this early period.

Modern medicine finds in the wisdom of ancient Greece its first great exemplars. Hospitals, as we understand the term, did not exist, but the temples of the gods both in Greece and Italy were the refuge of the sick, and there the priests or family of Aesculapius ministered to those ill of body or mind. In full consciousness, as Walter Pater expresses it, of "the religiousness, the refined and sacred happiness of a life spent in the relieving of pain."

Coming down to modern times, we find that light of the early nineteenth century, Walter Moxon, giving expression to much the same thoughts, "*sine missione nascimur*," we live to a duty, "It (the hospital) is to be to each individual sufferer under our care, all that a man can be to his fellowman in sickness."

In 1123, St. Bartholomew's of London was founded in the same religious spirit, by private funds donated at the solicitation of Prior Rahere. St. Bartholomew's, organized without ecclesiastic connection, naturally commended itself to the colonies in North America. Other early hospitals in England were: St. Gregory's, founded by Archbishop La Franc in 1084; Holy Cross Hospital, Winchester, 1132; St. Mary's, 1197; and St. Thomas', founded by Peter, Bishop of Winchester, in 1215.

In the year 1769, the colony of New York, with a population of 300,000 of whom only 20,000 lived in the city, had not a single hospital. Medical education in the Colonies was almost as backward. In 1767 a modest beginning had been made in New York by the establishment of a medical department in Kings College, now Columbia University. Two years later, in 1769, the graduating exercises of the first recipients of its medical degrees were, by a happy chance, held within the walls of the original Trinity church. A notable assemblage, including the Governor of the colony, Sir Henry Moore, was present. Lasting distinction was given the occasion by Dr. Samuel Bard, a student of Kings College and the London Hospital, a graduate of medicine of Edinburgh University, and professor of the practice of medicine in the college, who after addressing the two graduates on the high duties of their profession, elo-

quently urged on the community the crying need for a general hospital, not only for the care and relief of the sick but also as affording the best and only means of instructing students properly in the practice of medicine.

This moving appeal met with an immediate response, Sir Henry Moore then and there heading a subscription, and many contributions were received. Sir Henry did not live to see his work crowned, but the hospital was organized in 1770, and on June 13, 1771, in the term of his successor, the Earl of Dunmore, a royal charter was granted to "The Society of the Hospital, in the City of New York."

Steps were immediately taken to procure a site. The city offered a tract of three-quarters of an acre near where the present Municipal building stands. Trinity church which, in 1775, had given Kings College its grounds in Park place, offered the hospital a ninety-nine-year lease of a two-acre plot at Canal and Hudson streets. The society decided to buy a five-acre tract of land on an elevated site on the west side of Broadway, opposite Pearl street. Imposing hospital buildings were painstakingly planned and construction was pressed with all convenient speed. A staff of physicians, including Drs. Bard and Jones, was appointed and preparations for the reception of patients were made. But on the 28th of February, 1775, when the building was practically completed, an accidental fire consumed the interior, and, as the New York Gazette and Weekly Mercury described it, "This beautiful and useful structure, at once the pride and ornament of the city, became a ruin." The Governors made a fresh appeal for funds, four thousand pounds was granted by the Colonial Assembly, reconstruction was begun, and within a year the new hospital building was completed.

During the war of the Revolution, the hospital had a stormy career, and passed into the hands of British and Hessian troops, who used the hospital as barracks and occasionally as a military hospital. When the soldiers were withdrawn and the war ended, a tedious period of readjustment ensued, but not until January, 1791, was it that "this asylum for pain and distress," as the Governors feelingly described it, was finally opened for the treatment of patients.

The original structural group, containing about five hundred beds for patients, continued in active use until 1870, when the Governors of the society found the financial burden of maintaining a hospital on that spacious and valuable site too heavy to bear. They accordingly leased the grounds on long terms, vacated the buildings, and a new hospital was built on the present site, where the work of the society's general hospital has since been conducted.

The need for an emergency service in the lower portion of New York City became so acute that what was long known as the "Chambers Street Hospital" was established in 1875. From that date until 1894, when the modern Emergency Hospital was built, 320,000 patients were treated.

The illustrious names of William T. Bull and

Lewis A. Stimson are forever incorporated into the memorable history of this hospital.

The ambulance service was an important part of the work, which all told aggregated the imposing number of 245,000 calls.

The spirit of noble purpose, devoted and altruistic service which moved our ancestors to create and maintain these wonderful first hospitals, has been repeated in many cities of the United States. Will the modern hospital stand on the same high plane of purpose and achievement?

THE CURABILITY OF SYPHILIS *

By VICTOR G. VECKI, M. D., San Francisco

It is due to animal experimentation that we are able to claim that syphilis is a comparatively easily curable disease and able to hope that it may be abolished. All fixed rules, however, and all schedules must be abandoned. A proper diagnosis must be made, but the benefit of any doubt given to the patient. Every fresh case can and must be aborted. The intensity of the treatment is to be regulated by the patient's bodily condition and his tolerance for the remedies.

Minute care in the preparation of the patient, a faultless technic, heeding of any alarm signals and eventual reactions are absolutely necessary in order to finish intensive treatment without damaging the patient. Each subsequent treatment must be more intensive than the preceding one which failed to cure. Neurosyphilis demands slowly increasing doses, especially small first doses whenever vital parts may be involved. So-called parasymphilitic diseases, mainly *tabes dorsalis*, yield only to long, regular, persistent and proper treatment. The rhythmic, not the desultory, jerky treatment, accomplishes a cure. The intermittent treatment has failed, it must be abandoned and replaced by the continuous treatment, that is, until a cure is realized.

Recent experiences with the use of very small doses of silver-arsphenamin preparations make the use of mercury less and less imperative; it certainly is not very desirable. Kolle's experiments on animals have demonstrated that mercury is active against the spirochetes only in doses that come very near to the fatal ones.

Neosilver-salvarsan is the best arsenic preparation at our disposal, it is easy of solution, very slow to oxidize and is the most parasitotropic and the least organotropic of all antiluetic remedies. We know that silver itself is an antisymphilitic, its adding to the arsenic has not increased the toxicity, but only the effectiveness of the remedy. The silver molecule activates the salvarsan molecule. The arsenic being the spirilloicide, the silver takes the place of the considerably more toxic mercury to make conditions in the tissues unfavorable for the multiplication of the spirochetes.

There is no real evidence whatever of the dangerousness of the silver-salvarsan preparations.

* Abstract of a paper on the Curability of Syphilis read by Dr. Vecki at the Fifty-first Annual Meeting of the Medical Society of the State of California, held in Yosemite National Park, May 15 to 18, 1923.

Because of neosilver-salvarsan's low toxicity, the total dose in any given case can be reached quicker and safer and therefore the rhythmic, regular and persistent treatment is possible and our prognosis considerably better. Neurorecidives are never seen, intraspinal injections can be abandoned and replaced by draining of the spinal canal immediately after every third or fourth intravenous injection of neosilver-salvarsan.

The neglecting of proper iodide medication is responsible for many failures in the treatment of syphilis. Iodide is very effective when given intravenously.

The colorimetric reaction of Vernes, when once available everywhere, will enable us to reach periodically a quantitative diagnosis and also to judge when a patient really is cured.

We must positively avoid the dangerous condition created by stopping the treatment when almost all spirochetes are destroyed, and thus giving the few surviving clusters more favorable conditions for their pernicious activities. We agree with Vernes when he preaches that one must do too much in order to do enough.

Syphilis could be abolished when the recognizing of it and its effective treatment will be properly understood by the bulk of the profession, when it will not be considered a vice disease, but just a highly contagious one, and when those in power will understand that the proper fighting of this scourge would be by far cheaper than the support of all the hospitals, asylums, orphanages and prisons, populated by syphilitics and their tainted offspring.

(516 Sutter Street.)

Arizona State Secretary Visitor at Yosemite Meeting—D. F. Harbridge of Phoenix, Arizona, secretary Arizona State Medical Association, was a visitor at the fifty-first annual meeting of the Medical Society of California. Dr. Harbridge read a paper on "Sympathetic Iridocyclitis—a Case." The author contributes the case history of a patient, who after having the offending eye removed and his oral cavity made sanitary, recovered a vision 6/15 with a —4D. lens. A detailed pathological study by Finoff of the enucleated eye confirmed the clinical diagnosis. The various theories in explanation of the transference of the inflammation from the sympathogenic to the sympathizing eye, the possible relationship to tuberculosis, the very probable influence of an endogenous infection, and the bearing anaphylaxis may offer as a solution of the problem, is discussed.

Goat Gland Hospital for Ensenada—It is reported in the public press that Ensenada is to have a Goat Gland Hospital. The San Diego Cal. Union says: "A corps of surgeons, headed by Dr. Benson of Calexico, has leased the Felix Werber hotel at Ensenada for 15 years and is converting the building into a hospital. Associated with Dr. Benson, it is said, is one of the foremost surgeons of Kansas City. Hundreds of high class goats are to be shipped from San Diego to Ensenada by boat to furnish glands for patients at the new hospital!"

Date of 1923 Session—The Board of Trustees of the American Medical Association announces June 25 to 29, 1923, as the dates for the next Annual Session of the American Medical Association at San Francisco.

HAY FEVER—ITS CURE*

By D. H. TROWBRIDGE, M. D., Fresno, Calif.

My preliminary report of the treatment of hay fever by alcoholic injection was published in 1919 (Cal. State Journal Med., August, 1919).

I feel after treating one hundred and fifty additional patients, justified in the claim that my treatment cures hay fever. My practice is in a climate that is very dry and somewhat dusty—namely the San Joaquin Valley. Consequently there are a great many cases of hay fever. Formerly it was my custom to treat these patients with adrenalin, cocain spray, removal of spurs, and, in years past, by the removal of the turbinate bodies either in toto or in part, as well as by using all other methods of treatment then in customary use. The results were not satisfactory. Realizing the inefficiency of the mode of treatment, I determined to try a suggestion made to me by the late James A. Black of San Francisco—this being that alcohol injected into the nose would cure hay fever. There is no evidence that Black ever used the treatment extensively. If so he did not make further reference to it and I have not found any articles published by him in regard to it.

The first patient treated by this method suffered quite a severe reaction and the symptoms seemed to be much exaggerated for the first few days, after which the reaction subsided and the patient has not had a return of the trouble to this date. Naturally with this encouragement the treatment was carried out on other patients, at first with considerable doubt as to the results. Each patient was treated with the hope that the result might be successful but fearful that it would not be. Now, after several years' use of the alcoholic injection method of treatment, a cure is expected in every patient and failure causes much surprise.

Replies received to a questionnaire sent out in February of this year to one hundred prominent rhinologists in the United States and Canada, show only two men who had ever used the alcoholic treatment for hay fever. One specialist had used it to a considerable extent and a quotation from his letter is given below. The questionnaire was as follows:

How many cases of hay fever have you treated with vaccine?

What kind of vaccine used?

Did you use controls and specific vaccine or stock vaccine?

Kindly give results.

Have you used the alcoholic injection method?

How many cases?

What results?

The replies show that a great many rhinologists do not treat hay fever at all, nevertheless they seem to be interested, as many asked for reprints of my paper. About 40 per cent of the answers indicated that they had used the vaccines to a greater or less extent. Some had used stock vaccines from many manufacturers, while others had gone into the matter more scientifically and tested the patient for the specific pollen to which he

seemed to react and then treated each patient with a vaccine especially prepared or selected for the individual. The consensus of opinion from the replies received would indicate that those who had used the vaccine in any manner whatever had not been entirely satisfied with the results and that the relief obtained was in not more than fifty per cent of cases. Furthermore the benefit is evidently only temporary lasting perhaps during the season in which the treatment is given, or only while being administered. Certainly my results obtained by the use of alcohol in the treatment of this disease during the past six or seven years have been much better than those obtained by the use of vaccine. While the number of cases is perhaps not so large, many of the cases treated several years ago have had no return of the trouble, although they had been severe sufferers each summer for years previous to the treatment. I now expect about 90 per cent of cures.

Frank R. Spencer of Boulder, Colorado, reported that he had treated several cases with alcohol but did not state his method. He reported some as benefited, others not.

An extract from a letter received from Walter Reedy of Scranton, Pa., gives his experience with the alcoholic treatment. Reedy's plan is entirely different from my own and I quote the following from his letter:

"Injecting the nasal nerve (part of the naso palatine) as they entered the nostrils under the alae nasi. The alcohol was injected on both sides of the fraenum where the mucous membrane is reflected from the upper jaw to the lip. Through infiltration, when successfully done, the nerves are blocked. The patient complains of a numbness of the tip of the nose and upper lip. One patient called it a 'wooden nose.' I have used it in a number of cases of hay fever, rose fever, etc., and where the nerve block has been successful, the results have been good."

My technique has been to inject several minims of 95 per cent alcohol into each lower turbinate beginning at the posterior end and making three or four injections into the body of the turbinate with a long slender needle, also two or three injections of a similar amount of alcohol along the surface of each side of the septum. This is done in each nostril. No attention has been given to any special nerve or group of nerves.

The worst feature encountered in my method of treatment is that it is painful. No local anesthetic has been found that will prevent pain upon the injection of 95 per cent alcohol into the tissue. The patient has no feeling when the needle is inserted, but upon the injection of the alcohol the pain seems to radiate from the nose through the nerves up into the face and superorbital region and for something like a minute or two it is very severe. This is the most disagreeable feature in the treatment and it has kept some patients from receiving the benefit of the treatment who otherwise would have submitted to it. Very nervous patients may, of course, be given a general anesthetic and in the future I expect to use a general anesthetic more frequently rather than try to do the work under local anesthesia.

In most cases there is considerable reaction.

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at Yosemite National Park, May 16, 1922.

The mucous membrane is swollen and the patient has a disagreeable sensation of tumefaction for several days, after which it disappears. In many cases, within twenty-four hours the sneezing and disagreeable nasal irritation typical of hay fever disappears permanently. In a few cases the trouble has returned the following season and the patient had to submit to a second treatment. In cases where the results have not been good, the trouble appears to be due to faulty technique by which the alcohol escaped into the throat, or due to improper insertion of the needle, it may have passed through the turbinates and escaped behind into the pharynx. It is not as easy to confine the alcohol entirely to the turbinates as one would suppose and if particular care is not used more or less of it will be lost. When the alcohol is properly injected under local anesthesia, more or less intense pain immediately follows, whereas when it is not properly placed there is no pain. This in one way is a benefit as one can feel assured when the pain immediately follows the injections that the alcohol has been properly placed. Lately I have tried H. M. C. Compound hypodermatically together with local anesthesia which has seemed to lessen the pain somewhat. It is possible that this with local anesthesia will prove sufficient without resorting to a general anesthetic. Submucous resections and other operations may be combined with this treatment.

CASE REPORTS

One case reported in my former paper of August, 1919, was of a young man age 17, who had suffered for years from hay fever, so severe that each summer he was unable to work. He was treated four years ago and within a week was entirely relieved and able to work in the hay field with no return of the trouble. In a recent report he states that he has been entirely cured and is now having no trouble whatever.

Abstracts from the records of a few additional cases are submitted:

Miss H., age about 30 years, complained of hay fever for six or seven years. As a result of the trouble she was compelled to go to the coast each summer. She was given the alcohol injection on June 2, 1919, since which time she has had no return of the disease.

Mr. E., age about 65 years, referred to me by the mother of the young man previously mentioned in the former article. Mr. E. had suffered for twenty-five years from hay fever; had traveled extensively seeking relief and consulted numerous physicians without benefit. One treatment gave him complete relief.

Mr. T., age 19, had suffered for years. Was treated in 1919 and has had no return of the trouble to this date.

Mrs. C., age 19, treated six years ago. She was a severe sufferer from hay fever, practically an invalid during the summer months. A report received from her during the past week advises that she has been practically free from hay fever since the treatment.

Many other cases might be reported.

CONCLUSION

The great benefit of my method is that one treatment is usually all that is required to give permanent relief, whereas with vaccines many injections are required and the treatment must be kept up indefinitely. With the alcoholic treatment I obtain a cure or relief in 90 per cent of cases.

THE EFFECT OF MASSAGE, HEAT AND EXERCISE ON THE LOCAL CIRCULATION*

By ALBION WALTER HEWLETT, San Francisco
(From the Department of Medicine, Stanford University)

Despite the value of physiotherapeutic methods in the treatment of diseases which involve the extremities, we are still relatively ignorant of the manner in which these produce their beneficial effects. This is so largely because the study of joint and muscle functions has hardly advanced beyond the simplest measurements of motion and strength. Broadly speaking, physiotherapy is still in an empiric stage. Its methods have been and are being developed by the method of countless trials in one direction or another. The rational explanation of the results obtained is still fragmentary and scientific studies have not advanced sufficiently far in this field to give to physiotherapy the assistance already given to drug therapy and to treatment by the methods of immunology. None the less, a consideration even of certain functional changes, produced by physical methods of treatment, helps to clarify one's conception of what is happening in the tissues during the treatments.

My interest in this subject was awakened by studies on the blood flow in the arm which were carried out several years ago in association with J. G. Van Zwalenburg and others. These studies demonstrated plainly that the blood flow in the arm was readily and markedly influenced by certain physiotherapeutic procedures and that it was relatively unaffected by powerful drugs given in full therapeutic doses. Though our experiments have been published for some time it may yet be of interest to review the results, together with results of others, on account of the light they throw on certain methods commonly used in physiotherapy.

The arm is composed of skin, muscle and bone, together with various connecting tissues. Changes of circulation which occur in the arm may be assumed to occur under similar conditions at other portions of the surface of the body, where skin, muscle and bone make up the major part of the tissue.

It is well known that heat tends to increase the amount of blood in the heated tissues. The arm is said to swell as much as 70 c.c. when heated. Cold, if not too intense and too prolonged, has an opposite effect. Rings, gloves and shoes fit more loosely when one is chilly and more tightly when one is warm. These changes in volume are accompanied by corresponding changes in the rate of blood flow. The continued application of hot water to the arm increases the local rate of blood flow from four to eight times, and the continued application of cold causes the local rate to fall to one-half or one-fourth of the original. In one of our experiments, for example, the range of blood flow in the arm as a result of thermic influences varied from 2 to 40 c.c. per 100 c.c. of arm substance per minute.

The increased rate of blood flow produced by

* Read before the Section on Technical Specialties (California Association of Physiotherapists) at the Fifty-first Annual Meeting of the California State Medical Society.

heat is not a purely local phenomenon. Shortly after one arm is plunged into hot water the blood flow is increased not only in this arm but also in the opposite one, the latter being less markedly affected. In general the application of heat to any portion of the periphery of the body causes not only a local increase of blood flow but it appears to cause an increased circulation in all portions of the body surface. The response of distant portions of the surface is often so prompt that it must be due in part to nervous reflexes.

Thermic influences may bring about a redistribution of blood in still a third way. This is through an alteration in the body temperature. We know that if a person becomes overheated, the heat-regulatory centers throw into operation all those mechanisms which serve to lower the body temperature. Most important of these is an increased rate of blood flow through the surface covering of the body. This warms the skin and so increases the heat losses from the body. The central mechanism which regulates the body temperature is sensitive to slight alterations in the temperature of the blood which comes to it. If any procedure raises the temperature of the body, even slightly, then the regulatory mechanism tends to send more blood to the periphery of the body in order to reduce the temperature. Thus we see that thermic influences alter the rate of circulation at the surface of the body in three distinct ways: (1) through their local effects, (2) through reflex influences, and (3) through altering slightly the temperature of the blood which goes to the brain.

This latter appears to me to be of paramount importance in securing a good reaction after the cold procedures. Every hydrotherapist knows that the patient must not be allowed to become chilly after a cold procedure and the whole technic of general hydrotherapy is designed so as to obtain that feeling of warmth and comfort which characterizes a good reaction. This is accomplished largely by measures which prevent heat losses from the body. The rooms are kept warm, the patient is given a preliminary hot treatment, and the cold procedure is made very brief. The heat added to the body during the preliminary treatment more than compensates for what is extracted during the cold procedure. The temperature of the body is a little elevated; and although the cold procedure by its local effect drives the blood from the surface, the latter soon returns after the cold is removed and the skin remains warm because of the slight increase in body temperature. Vigorous persons commonly forego the refinements of the hydrotherapeutic institute and obtain reactions in cold rooms and without preliminary hot procedures. It appears to me that they are able to do this largely because vigorous exercise during the bath liberates heat within the body. This liberation, combined with a constriction of surface blood vessels during the cold procedure, more than overcomes the tendency of the cold to extract heat from the body. At the end of such a cold bath the body temperature is actually higher than at the beginning and the individual is left with a

pleasing feeling of warmth that persists after the bath is over. In the course of the experiments referred to above, I took not a few cold showers after my body temperature had been slightly reduced by prolonged exposure; and I can testify that under such circumstances even one who ordinarily reacts well and who is comfortable during and immediately after the shower is apt shortly to experience intense chilliness that persists until the body temperature has finally been raised to the proper level. Thus it seems to me that one of the essential conditions for an enduring reaction after a cold procedure is a maintenance or even a slight elevation of the body temperature as a net result of the entire procedure. This ensures the continued feeling of warmth and the normal or increased blood flow to the surface that characterizes a good reaction.

The blood flow through the arm is accelerated not only by heat but also by the voluntary use of the local muscles. We found, for example, that the rate of blood flow in the arm may be increased to from three to eight times the resting flow by rapidly opening and closing the fist. Of no little interest are those observations made by others which indicate that this increase of blood flow during exercise depends less upon the mechanical effect of the motion than upon vasomotor effects caused by voluntary innervation of the muscles used. Muscular contractions produced in animals by stimulating the local nerves seem to have been much less effective in accelerating the local blood flow than the muscular contractions produced by voluntary innervation. Furthermore Weber reported that marked swelling of the arm may be produced in motionless persons during hypnotic sleep merely by the suggestion of motion in this arm. Thus it would appear that the marked increase in local blood flow which accompanies muscular movements is due largely to the voluntary effort made to use the muscles. Here we have suggestive physiologic grounds for encouraging a patient repeatedly to make the effort to use an extremity provided use is desired; even though on account of injury or disease he can actually move it very little.

So far as the local blood flow is concerned, massage is not the equivalent of exercise. Exercise causes a marked swelling of the arm due to the increased amount of blood that it contains, but massage produces no appreciable effect upon the arm volume. Under suitable conditions therefore massage should be combined with voluntary efforts on the part of the patient to use his muscles.

We have seen that two types of procedure commonly used in physiotherapy have an extraordinary effect in accelerating the blood flow through an extremity. These are the voluntary use of the muscles and the application of heat either local or general; and I may repeat that no medicine produces an effect even remotely comparable to that caused by these physical methods. It seems to me evident that such a marked acceleration of the circulation as is produced by these means cannot be without influence upon local disease.

EDITORIALS

MEDICAL DEFENSE AND INDEMNITY DEFENSE

The Council on May 18th last, directed the secretary of the State Society to send postal questionnaires to members on the subject of Indemnity Defense. Three questions were asked, as follows:

1. Are you a member of the Indemnity Defense Fund?
2. Are you otherwise insured against malpractice?
3. If so, name of company or companies, with the amount in each company.

Three thousand four hundred and twenty-five cards were sent out and some of the replies received have occasioned this article.

The questionnaire was prompted by the desire of the Council to obtain data which would be of value in meeting adequately a question which merits earnest consideration by each of the society's members; namely, strengthening our organization to resist unmeritorious claims and suits.

These suits are increasing in number; a greater number of cases are being decided in favor of claimants, and the size of judgments rendered in these cases is becoming larger.

Some members of the society, despite the strongest evidence to the contrary, still seem to feel immune to this type of attack on their reputation and property. This fancied security frequently is lost under startling and disturbing circumstances. Our records show that these suits are brought against physicians in all kinds of practice, whether surgeons or not, and without any basis in scientific facts.

Some of the answers received to the questionnaire suggest the following statement: Any member of the society in good standing is entitled in any malpractice case, where his position is meritorious, to payment of all court costs and attorney's fees in his behalf. This protection, available to every member in good standing, is termed Medical Defense. If in such a case, a judgment for damages is obtained against a member, the member must pay such judgment himself; in other words, the society merely furnishes the attorney and pays court costs.

In order to provide for protection against possible adverse judgments, the society established the Indemnity Defense Fund in 1916. Any member in good standing can join this Fund on payment of \$15 in cash, and give his note for \$15 without interest, payable one year thereafter. In all malpractice claims or cases against a member of the Fund, the society pays all court costs, furnishes the attorneys, and in event of adverse judgment, pays such judgment up to the amount of \$5,000 in any one case.

As to malpractice claims and cases, therefore, the society affords two types of service to members; the first, Medical Defense, which includes court costs and attorney's fees, but does not take

care of adverse judgments; the second, Indemnity Defense, which includes the payment of all court costs and attorney's fees and any adverse judgment up to the sum of \$5,000.

Some of the members ask: "Do you advise me to carry insurance in addition to my membership in the Indemnity Defense Fund?" The council and officials of the State Society have taken a uniform stand on this question, which has been presented to members by letter and articles in the Journal heretofore. If a member has no insurance, he is advised to join the Fund; if he has insurance, he is advised to join the Fund. A member carrying insurance is advised not to drop it, but keep it in force for the reasons above stated. Verdicts in this type of case, when rendered, show a decided tendency to increase in size, typically in certain types of action. Of course, a great deal depends on the doctor's clientele, the character of work done by him, the number and reliability of assistants and numerous other phases, as to which we will be glad to advise any member who will write to this office in detail concerning it.

PROPAGANDA

The subtleties and finer points, as well as the curiously oblique ethics which form the basis of "propaganda" as distinguished from "advertising" on the one hand and "education" on the other hand, are perhaps the most confusing, least understood and yet one of the most important subjects before the public. Propaganda by the ton is being fed to the public daily everywhere, disguised as "news," "education" or "informative publicity."

Physicians should study the subject seriously in their own interests and more particularly in the interests of their friends and patients. This because the broad field of public health and medicine is proving one of the most profitable for "propagandists" who are succeeding to a degree in many instances and by various means in "educating" not only the public, but some physicians in health movements, methods and procedures.

Our mail contains many inquiries from physicians as to the merit of this or that welfare organization, new (?) suggestions, methods or what not. In most of these instances a little investigation and serious thought would have uncovered the truth.

Recently the North American Review published a series of three articles upon this subject and E. K. Strong has a splendid article in the last issue of the Scientific Monthly. Strong says:

"The word 'propaganda' means essentially the spread of a particular doctrine or a system of principles, especially when there is an organization or general plan back of the movement. Propaganda differs from 'education,' with which it is purposely confused, in that in the case of the former the aim is to spread one doctrine, whereas in the case of the latter the aim is to extend a knowledge of the facts as far as known.

"Advertising men have never been able to agree on a definition of 'advertising' and I should not want to attempt here what they have failed to do. But I think we can distinguish between advertising and propaganda by saying that advertising is usually concerned with making known and desirable a definite commodity or service with the definite

aim of leading many individuals, as such, to acquire the commodity or service. Propaganda includes many types of advertising, but it is mainly concerned with the subtle presentation to the public of information so chosen and so focused that among many individuals there develops a general 'point of view' which is favorable to the aim of the propagandist and leads to action in that general direction. A further distinction between these two methods of influencing people pertains to the **methods** employed rather than the **object**. The advertiser buys space upon which appears his message, and the reader knows it as a paid advertisement. The propagandist may advertise, but he especially aims to employ space he did not buy, at least directly, and not to permit the reader to know that the material is propaganda. He believes his material will have greater effect when its source is unknown.

"We are so accustomed to our political machinery that we do not often stop and ask ourselves whether it is geared up so as to serve society in the best way. Only when some enthusiastic social uplifter boasts that she and four others alone put a measure through a state legislature by the use of skillful lobbying, or a secretary of a business man's organization calmly announces months in advance that Congress will do away with a bureau because his organization is demanding such action, and his prophecy comes true, does one wonder whether some sort of control of propaganda would not be worth while even here. And one waxes quite indignant, as did a former Secretary of War, when he comes to realize that much of the propaganda for bringing back the bodies of our dead soldiers was instigated by the journal of the undertakers and casket makers."

He concludes:

"As far as I can see, society has reached the point in its development when it must take motives into account, because man has now learned how to arouse motives to action in an economical and wholesale way. And in regulating motives society must come to evaluate the sentiments that propaganda is aimed to create, and to regulate in some way the use of phrases arousing emotions as distinguished from phrases appealing to rational consideration. Without control in some way of the emotional element in propaganda, legal action will never stop the most dangerous of propaganda which arouses a sentiment first of all and then at the proper moment in one fell swoop precipitates that sentiment into action."

It would be well for physicians as guardians of public and personal health to establish the habit of critical reflection and make a point of fair interpretation for their patients of much that now appears in print as "education," "public health and medicine information." The subjects discussed include practically the entire field of medicine and public health and there is usually a motive and an interested organization just beneath the surface.

VITAMINS

Vitamins should be purchased from the market, the grocery and the dairy instead of the drug store.

Some pharmaceutical houses are spending a great deal of money in efforts to induce physicians to prescribe vitamins. Patent medicine vendors and a host of other quack concerns are spending huge amounts of money in an attempt to "educate" (?) the public as to the great value of vitamins, and, of course, the product offered by each advertiser is the only one that contains the real Simon-pure, life-giving "A" "B" and "C" vitamins.

It is the duty of physicians to inform their

patients and it is the duty of the medical profession to inform the general public that the best and most useful and all that is necessary of vitamins can be purchased for a few cents a day from the dairy and the market. Furthermore, it is our duty to tell the public that some of the most extensively advertised and used of these products have not sufficient vitamin "C" to protect guinea pigs from scurvy when given in doses recommended as sure protection for children.

In fact, except under certain special conditions, which can be appreciated only by the educated physician, there is no excuse, except one of financial profit for soul-scarred commercialists, for creating a demand for these products.

HOSPITAL BETTERMENT WEEK IN CALIFORNIA—SECOND ANNUAL CONVENTION OF THE HOSPITALS OF CALIFORNIA.

(Held Under the Auspices of the League for the Conservation of Public Health, Maryland Hotel, Pasadena, September 5, 6, 7, 8, 1922.)

A real post-graduate week of study and instruction in hospital betterment; a program of constructive discussion, question and answer conference, and application for all people interested in any phase of hospital betterment.

During the same week, there will be meetings of the Council of the Medical Society of the State of California; of the Council and officers of the State Society with the officers of County Medical Societies from all parts of the State; and of the Program Committee of the State Medical Society, including the section officers of all sections of the State Medical Society. There will be exhibits, scientific, technical and commercial, showing the best in professional and technical service in California hospitals, as well as the best in equipment, furnishing and supplies.

A strong committee from Southern California, under the chairmanship of Dr. Charles D. Lockwood, is arranging an interesting and attractive social and recreational program. Headquarters will be at the Maryland Hotel, Pasadena. This hotel, as well as others in Pasadena and Los Angeles, have made exceedingly satisfactory American plan rates. The social and get-together features of this convention, as well as the serious sessions, will be very attractive.

Every hospital in California, regardless of its ownership, method of management, whether it is general, special or private, is invited and urged to send as many people as possible to the convention. Each hospital, regardless of its size and character, is entitled to delegates as follows: One representing each of the following: Ownership, directorate, administration, staff, nursing and all other professional and technical departments.

For hotel reservations, address Mr. H. M. Nickerson, resident manager, Maryland Hotel, Pasadena.

For any problem of any kind pertaining to the convention, address Dr. Charles D. Lockwood, chairman Committee of Arrangements, 295 Markham Place, Pasadena, or Dr. W. E. Musgrave, chairman of the Section on Medical Economics, Education and Hospitals, 806 Balboa Building, San Francisco.

SYNOPSIS OF PROGRAM

All meetings will be held in the Maryland Hotel, Pasadena.

First Meeting—Tuesday, September 5, 10 to 12:30.

This meeting will be devoted to special informative 10-minute lectures of vital interest to everybody.

Second Meeting—Tuesday, September 5, 2:30 to 5 p.m.

This meeting will be given over to general consideration of common hospital problems; four speakers,

ten minutes each, each subject to be followed by a general discussion. Meeting to be closed by 30 minutes of questions and answers. Anybody in the audience may ask any questions on any phase of hospital administration.

(This question and answer conference will close every meeting of the convention.)

Third Meeting—Wednesday, September 6, 10 to 12:30.

The general subject of this meeting is "The Physical Plant of the Hospital." There will be three 10-minute addresses with free discussions by everybody, and the meeting will close with thirty minutes of questions and answers.

Fourth Meeting—Wednesday, September 6, 2:30 to 5 p. m.

The general subject for this meeting will be, "Owners, Governing Bodies and Chief Executives of Hospitals." Again there will be three 10-minute addresses, followed by general discussion, and the meeting to be closed by a question and answer conference as mentioned above.

Fifth Meeting—Thursday, September 7, 10 to 12:30.

The general subject will be, "Clinical Departments and Services for both the Hospital and Dispensary. The carefully prepared ten-minute addresses at this meeting will include questions of staff organization in general, as well as by departments; the relation of the general practitioner to the hospital staff; the relation of groups to hospitals and the relation of dentistry for the hospital, together with the usual standard staff departments. The general four-minute discussions will be open to everybody, and the meeting will be closed by the thirty-minute question and answer conference.

Sixth Meeting—Thursday, September 7, 2:30 to 5 p. m.

This meeting will be devoted to the General Utility Departments and Services of the hospital. The ten-minute addresses will include pathology and clinical laboratories; the hospital department of public health; the departments of radiology, and the technical departments of physiotherapy, pharmacy, nursing, public health nursing and medical social service, clinical records and library. The four-minute discussions will be general and every one will be invited to take part in them. The meeting will close with the thirty-minute question and answer conference.

Seventh Meeting—Friday, September 8, 10 to 12:30.

This meeting will be devoted entirely to the problems of Hospital Administration. The selected ten-minute addresses will cover the field of general administration; finances and accounting; property and supplies and transportation; laundry and linen services; subsistence and dietetics. Four-minute discussions will be open to everyone, and the meeting will close with thirty-minute question and answer conference.

Eighth Meeting—Friday, September 8, 2:30 to 5 p. m.

The concluding meeting will be a business meeting, with discussion of reports of the resolutions committee and other committees.

Hospital Betterment Service Bureau

In addition to the regular program, members of the Section on Medical Economics, Education and Hospitals of the League, assisted by experienced persons on every character of hospital problem, will hold special informal conferences every evening at 8 o'clock in the League headquarters at the Maryland Hotel. These meetings are open to all persons, and anyone with any particular hospital problem is invited to present it for discussion and solution at these conferences. Only specific problems will be considered at these 8 p. m. meetings.

OFFICERS AND COMMITTEES, LEAGUE FOR THE CONSERVATION OF PUBLIC HEALTH

Section on Medical Economics, Education and Hospitals
W. E. Musgrave, M. D., chairman; William Ophuls, M. D., John H. Graves, M. D., Percy T. Magan, M. D., Dudley Fulton, M. D.

Officers

Dudley Smith, M. D., president; Granville MacGowan, M. D., vice-president; W. T. McArthur, M. D., secretary; W. B. Coffey, M. D., treasurer; Hartley F. Peart, counsel.

Executive Committee

C. D. McGettigan, M. D., chairman; Walter V. Brem, M. D., O. D. Hamlin, M. D., Saxton T. Pope, M. D., James W. Ward, M. D., Celestine J. Sullivan, executive secretary.

Committee on Arrangements for the Convention

Dr. Charles D. Lockwood, chairman; Bishop Joseph H. Johnson, Good Samaritan Hospital; Mrs. Laura L. Mitchell, Pacific Hospital; Mr. Norman Martin, Los Angeles County Hospital; Dr. N. N. Wood, Los Angeles County Hospital; Miss Melissa Wittler, Methodist Hospital; Mrs. Harriet W. Fahl, Angelus Hospital; Dr. E. T. Dillon, St. Vincent's Hospital; Sister Mary Ann, St. Vincent's Hospital; Dr. Percy T. Magan, White Memorial Hospital; Dr. Joseph K. Swindt, Pomona Valley Hospital; Dr. C. Van Zwalenburg, Riverside Community Hospital.

Rules of the Hospital Convention

1. All meetings are open to the public. Physi-

cians, dentists, physiotherapists, nurses, public health nurses, medical social workers, dietitians, radiographers, laboratory technicians, architects and other persons interested in the Hospital Betterment Movement are especially urged to attend these meetings.

2. The speaker opening a subject will be limited to ten minutes; the discussions will be limited to four minutes each. No discussant may speak more than once upon any topic, and the chair may not grant extension of time beyond the specified limit. General discussion by delegates and visitors invited.

3. Each hospital is entitled to send one official representing ownership; its directorate; the administration; the staff; nursing and all other professional and technical departments.

4. All resolutions shall be presented in writing to the chairman and referred to the Committee on Resolutions, without comment.

Other Meetings Held in Connection With the Hospital Convention

The council of the State Medical Society will hold two meetings (for Councilors only). The first meeting will be held Friday, September 8, at 10 a. m., at the Maryland Hotel. It will adjourn for luncheon at the hotel and continue its session until the business is transacted. The second meeting will be held Friday evening, September 8, at 8 o'clock, at the Maryland hotel. This meeting is for a special purpose and will be an executive session.

There will be a meeting of the Council with State and County society officers, Saturday, September 9, at 12:30, at luncheon in a special dining room at the Maryland hotel. At this meeting it is requested that presidents, secretaries and assistant secretaries and any other officers of county societies from all over the State, meet with the Council and officers of the State Society for discussions of problems affecting the progress of medicine and the welfare of medical organization.

The program committee of the State Medical Society will meet with section officers of each section of the State Society, Saturday, September 9, 10 a. m., Maryland hotel. This is an important meeting, to arrange the program and plans for the next annual meeting of the State Society, as well as for the conduct of the State Society's business, and co-ordinating it with the various section activities of the State Society throughout the year.

Tuberculosis Association and Illinois "State Medicine"—"The Illinois Tuberculosis Association is distributing a pamphlet dealing with the tuberculosis clinic as it is conducted by the association. In view of the fact that many physicians in the State are more or less antagonistic to what is termed 'State medicine,' the Illinois Tuberculosis Association explains in detail the purpose of its clinics.

"The clinics are diagnostic clinics. They have nothing to do with the treatment of patients. They are held only in conjunction with the county medical society or the local medical profession. The individual local physicians are invited to bring their own patients to the clinics or to express their approval of their patients being invited to the clinics. The clinics are held chiefly with the medical profession, for the medical profession and by the medical profession.

"Nurses and other arranging clinics are particularly urged not to present patients for examination except with the approval or in the presence of the patient's family physician. When the family physician is unable, for any reason, to attend the clinic where his patient is examined, the nurse is expected to convey to the family physician the diagnosis and suggestions made by the clinician."—(Long Island Medical Journal, May, 1922.)

STATE SOCIETY

ABSTRACTS FROM THE MINUTES OF THE 130th, 131st, 132nd AND 133rd MEETINGS OF THE COUNCIL OF THE STATE MEDICAL SOCIETY

(Held at Yosemite National Park, May 15 to 18, 1922)

Madera County Medical Society—The secretary reported that the physicians of Madera County had voted to organize a county society and had requested a charter from the State Society. Upon motion of Bine, seconded by Van Zwalenburg, it was

Resolved, That this newly created medical society be recognized and the secretary authorized to issue a charter to them.

Industrial Accident Law—The question of a circular letter recently sent out by the Industrial Accident Commission requiring every physician to report to the Commission all accident cases treated by him, whether industrial cases or not, was brought up for discussion. On motion of Bine, seconded by Graves, it was

Resolved, That the matter be referred to the general attorney for advice as to whether or not the law requires that every physician report to the Industrial Accident Commission every accident he is called upon to serve;

Resolved further, That if in the opinion of our attorney this is the correct interpretation of the law, he advise the Council of the method of procedure to endeavor to have this law amended.

Appointment of Trustee of Indemnity Defense Fund—The term of office of Rea Smith as trustee of the Indemnity Defense Fund having expired, upon motion of Kress, seconded by McArthur, it was

Resolved, That William Duffield of Los Angeles be appointed to fill the vacancy caused by the expiration of the term of Rea Smith.

Advertisements of Physicians in Newspapers—A letter was presented by the secretary from Dr. — in regard to the rather flamboyant advertisements in certain newspapers by certain physicians in Fresno, San Francisco and elsewhere, and asking for our instructions. The secretary stated he had answered the letter to the effect that the matter would be referred to the Council, but that undoubtedly the advertisements in question were unethical. It was voted by the Council that the communication of the secretary be approved and that the advertisements in question be brought to the attention of appropriate local county societies.

Baynes' Article in Woman's Home Companion on the Truth About Vivisection—It was voted that a letter be written to the Woman's Home Companion, commending them on their stand in regard to vivisection.

It was further voted that a copy of the letter be published in the State Journal of Medicine, with an editorial note suggesting to all members that they also write and express their approval of the stand taken by the Woman's Home Companion and the discussion they are giving the question in their publication.

Roster of State Society Members—Discussion was had as to the advisability of printing a roster of members of the State Society for 1922. Upon motion duly made and seconded, it was voted that the Society discontinue the printing of the roster.

New Sections on Scientific Work—The Council having heard the report of the secretary on proposed new sections, upon motion of Bine, seconded by Paterson, it was

Resolved, That the creation of the following new sections be approved, and the secretary be instructed to take the necessary steps to make this action effective:

1. Section on Physiology, Chemistry and Pharmacology, including Physiological Chemistry,

Biological Chemistry, Pharmacy, Chemotherapy, and similar allied sciences;

2. Section on Anatomy, including Surgical Anatomy, Embryology and similar closely allied sciences;

3. Section on Applied Biology, including Parasitology, Serology, Immunology and similar closely allied subjects;

4. Section on Dermatology.

Reorganization of the Council—Upon motion of Edwards, seconded by McArthur, C. G. Kenyon was unanimously re-elected chairman of the Council for the ensuing year.

Appointment of Councilor for Third District—Upon motion of Paterson, seconded by Brainerd, Garth Parker of Salinas was appointed to fill the vacancy in the Third District caused by the resignation of T. C. Edwards as councilor for that district.

Indemnity Defense Fund—After general discussion of methods of increasing membership in the Indemnity Defense Fund and of the cost of medical defense, upon motion of Paterson, seconded by McArthur, it was

Resolved, That the secretary be instructed to circularize the members of the society, to ascertain how many are insured in private insurance carriers and the amount of insurance carried.

MINUTES AND PROCEEDINGS OF SECTIONS OF THE FIFTY-FIRST ANNUAL MEETING OF THE MEDICAL SOCIETY OF THE STATE OF CALIFORNIA

(Only part of the Sections have submitted minutes. These are published.)

SECTION ON GENERAL SURGERY

CHARLES D. LOCKWOOD, Chairman
EDMUND BUTLER, Secretary

First Meeting, May 16, 1922, at 8 p. m.—The fourth annual session of the General Surgical Section was called to order by Chairman Lockwood. Following the chairman's address, the minutes of the 1921 session were read and approved. Papers read during the first meeting were as follows: "Amputation Region of the Knee Joint," by Howard H. Dignan of San Francisco; discussed by Emmet Rixford of San Francisco, Leo Eloesser of San Francisco and W. W. Richardson of Los Angeles. "The Hemorrhoid Problem," by Sol Hyman of San Francisco; discussed by H. H. Shirk of Pasadena, G. Rothganger of Oakland, E. Rixford of San Francisco, W. A. Clark of Oakland, LeRoy Brooks of San Francisco, O. O. Witherbee of Los Angeles, W. A. Jones of Riverside. "Migratory Tumors of the Abdomen," by Asa W. Collins of San Francisco; discussed by Burt S. Stevens of San Francisco; "Amoebic Abscess of the Liver," by Horance J. Brown of Goldfield, Nevada; discussed by Herbert Gunn and Herbert Moffitt. The paper of Rea Smith of Los Angeles was not read because of the inability of Dr. Smith to attend. "The Underlying Principles of Plastic Surgery," by J. A. Pettit of Portland, Oregon, was transferred from the May 18 session; discussed by William J. Mellinger of Santa Barbara. "Tumors of the Breast Arising During Lactation and Pregnancy," by Alson R. Kilgore of San Francisco; no discussion.

Second Meeting, May 17, 1922, at 2 p. m.—The meeting consisted in a symposium on bowel obstruction with the following papers: "Indications For and Results of Anchoring the Head of the Colon," by O. O. Witherbee of Los Angeles. Andrew S. Lobingier was not able to attend the meeting. The secretary was notified February 25, 1922, but through some mistake the program was not corrected. "Bowel Obstruction, Diagnosis and Treatment," by Emmet Rixford of San Francisco. "Some Observations on Intestinal Obstruction," by Harold Brunn and George K. Rhodes; read by Harold Brunn. "Bowel Obstruction Following Abdominal Operations Occurring During Convalescing Period," by Alanson Weeks and LeRoy Brooks; read by LeRoy Brooks; discussed by E. C. Rich of Ogden, Utah; W. W. Cross of Fresno, James F. Percy of San Diego, W. L. Huggins of Los Angeles, and J. H. Shepard of San Jose. "Surgical Study of Periarterial Sympathetic Fibers," by C. Latimer Callender; discussed by Stanley Stillman, Leo Eloesser, E. Rixford, H. Brunn, P. K. Brown, E. I. Bartlett, all of San Francisco, and W. A. Clark of Oakland. Adjournment.

Third Meeting, May 18, 1922, at 2 p. m.—Election of officers for the 1923 session. The chairman appointed O. O. Witherbee, W. W. Richardson to act with W. A. Clark, the retiring chairman of 1921, on the Executive Committee. Stanley Stillman of San Francisco was elected chairman. Harlan Shoemaker of Los Angeles, secretary and Leo Eloesser, assistant secretary for 1923.

The following papers were read: "Adenomatous of the Thyroid," by John Hunt Shepard of San Jose; discussed by Carl Hoag and E. I. Bartlett. Clarence Toland did not appear to read his paper. "Compression of the Lung in Tuberculosis, Medical and Surgical Aspects," by Leo Eloesser of San Francisco and Philip King Brown of San Francisco. "The Diagnosis and Treatment of Surgical Lesions of the Chest," by Charles D. Lockwood of Pasadena; discussion of the two previous papers by W. J. Kerr of San Francisco, C. A. Warner of Los Angeles, C. L. Callender of San Francisco, D. Frick of Los Angeles, H. E. Schiffbauer of Los Angeles and O. O. Witherbee of Los Angeles. "False Diverticulitis of the Sigmoid," by Stanley Stillman of San Francisco; discussed by E. Rixford, J. H. Shepard and C. Hoag.

The attendance was very good at all three sessions. W. A. Clark of Oakland moved that a vote of thanks be extended to the chairman, Charles D. Lockwood, for providing a very interesting and timely program.

SECTION ON UROLOGY

G. W. HARTMAN, Chairman
LOUIS CLIVE JACOBS, Secretary

The Urological Section of the Medical Society of the State of California held meetings on May 15 and 16. The program, as published in the May issue of the Journal was carried out, except that the paper of Granville MacGowan of Los Angeles was not read, due to his absence. The Nominating Committee presented the names of Robert V. Day for chairman and Louis Clive Jacobs for secretary for the ensuing year. It was duly moved and seconded that the nominations be closed and the motion was carried. The candidates were then duly elected.

SECTION ON OBSTETRICS AND GYNECOLOGY

HARRY M. VOORHEES, Chairman
L. A. EMGE, Secretary

The following is an abstract of the minutes of the meetings of the Section on Obstetrics and Gynecology. The following resolutions were passed:

1. That one hundred dollars be expended from the "Stenographer's Fund" to cover the expenses of recording and transcribing the discussions of the various papers given.
2. That the secretary of the State Society be notified that all discussions, properly edited, shall be published together with the original article in the Journal of the State Society.
3. That the secretary of the Section on Obstetrics and Gynecology shall keep a registration list of all physicians who wish to take active part in the section meetings.
4. That next year's program shall include at least two meetings in which symposiums will take the place of individual papers.

The symposiums to be on: (1) Sterility, (2) Posterior Positions and Their Treatment, (3) Operative Versus Radiation Treatment of Benign and Malignant Tumors, (4) The Application of Episiotomy and Low Forceps. All those who wish to take part in the symposiums should communicate with the secretary of this Section at once so that special problems may be assigned. The officers elected for the coming year are: Dr. L. A. Emge, chairman, Stanford University Hospital, San Francisco, and Dr. J. Morris Slemmons, secretary, Los Angeles.

SECTION ON NEUROPSYCHIATRY

W. F. SCHALLER, Chairman
W. B. KERN, Secretary

The session was well attended, evidently larger than any previous session. The program was carried out in full. Officers elected for the ensuing year were: Ross J. Moore of Los Angeles, chairman, and Charles I. Tranter of San Francisco, secretary.

SECTION ON ORTHOPEDIC SURGERY

W. W. RICHARDSON, Chairman
G. J. MCCHESENEY, Secretary

The first meeting of the Section was held on Tuesday afternoon, May 16, W. W. Richardson, Los Angeles, presiding. After his opening address, a paper by A. L. Fisher, San Francisco, on "Congenital Elevation of the Shoulders With Operation For Cure," was read by Sol Hyman, San Francisco, in the absence of Fisher. The next paper was "The Treatment of Painful Affections Involving the Cervical Vertebrae," by H. L. Langnecker, San Francisco. The third paper was by C. G. Stivers, Los Angeles, the subject being "Re-Education of Crippled Children." The last paper of the afternoon, illustrated by numerous lantern slides, was on "Repair of Tendons in the Fingers," by Sterling Bunnell, San Francisco. H. A. Rytkogel, San Francisco, did not appear to read his paper as per program.

The second meeting was held on Wednesday evening, May 17. The first business was the election of Section officers, which resulted in the appointment of George J. McCheesney, San Francisco, as chairman for the ensuing year, and H. H. Markel, San Francisco, as secretary. As the meeting is to be held in San Francisco, it was thought advisable to have both officers from that city. There being no other Section business the scientific program was continued. James T. Watkins, San

Francisco, read a paper on "Dislocation of the Hip Into the Obturator Foramen." George J. McCheesney, San Francisco, read a paper on "The Modern Treatment of the Weak or Flat Foot." A Gottlieb, Los Angeles, read a paper on "Brisement Forces and the Pre- and After Treatment." H. L. Schurmeir, Los Angeles, read a paper on "Congenital Deformities." This closed the meeting, which was regarded as highly satisfactory by all who attended.

SECTION ON INDUSTRIAL MEDICINE AND SURGERY

E. W. CLEARY, Chairman
PACKARD THURBER, Secretary

First Meeting, May 15, 1922—The secretary suggested to the various members that they hand in abstracts of their papers to the Section's secretary early in the year to facilitate preparation of the program. The address of the chairman covered some of the important problems in industrial surgery. The chairman announced that due to illness three of the men scheduled to give papers were unable to attend. The following papers and discussions ensued: "The Necessity for More Accurate Data in the Surgeon's Permanent Disability Report," E. E. Raynes; "Misuse of the Industrial Accident Fee Schedule," Morton Gibbons; discussion by Gayle G. Mosely, Hunkin and Carl Hoag of San Francisco, H. J. Brown of Goldfield, Nevada; E. C. Cleary and Morton Gibbons, San Francisco. A motion was made by Charles Mooney of Santa Rosa that a committee be appointed to draw a resolution to the State Society regarding fees and underbidding. The chairman appointed on this committee Morton Gibbons, San Francisco, chairman; Charles Mooney, Santa Rosa and Philip Stephens, Los Angeles. The next paper was "Resection Distal End of the Ulna For Shortening of the Radius Following Fracture," Carl Hoag, San Francisco; discussion by Spier of Los Angeles, George McCheesney, T. J. Watkins, E. W. Cleary and Carl Hoag of San Francisco. So-called "Chauffeur's Fractures" was the subject of a paper by Philip Stephens, Los Angeles; discussion by Langnecker, Hunkin and Stephens, San Francisco.

Second Meeting, May 18, 1922—"The Necessity For An Immediate and Thorough Roentgenological Study of All Injuries to the Spine," H. W. Chappel, Los Angeles; discussion by Schumier, Santa Barbara, Harlan Shoemaker, Los Angeles, Hunkin, Adams and Gould, San Francisco, Chappel of Santa Barbara. Philip Stephens of Los Angeles was elected chairman, and Packard Thurber, Los Angeles, secretary. The committee appointed at the first meeting to draft a resolution on fee cutting made a report. The resolution was passed. (This resolution was published in the minutes of the Council in the July Journal.) "Fracture of the Pelvis With Particular Reference to Dislocation of the Sacro Iliac Synchondroses," Harlan Shoemaker, Los Angeles; discussion by Prince, Hunkin, Cleary, Mosely, McCheesney and Shoemaker of San Francisco. "Industrial Medicine and the General Practitioner," Gayle G. Mosley; discussion by Morton, Gibbons, Cleary and Mosley, San Francisco. "Physiotherapy Treatment in Industrial Rehabilitation," A. R. Gould; discussion by Morton, Gibbons, Koye, Mellinger, Shoemaker, Adams, Hunkin, McCheesney, Gibbons, Cleary and Gould. Harlan Shoemaker of Los Angeles made a motion that a committee be appointed to investigate physiotherapy and report at the next industrial section meeting. The motion was carried and the chairman announced that a committee would be appointed at a later date.

SECTION ON PATHOLOGY AND BACTERIOLOGY

WM. OPHULS, Chairman
R. W. HAMMACK, Secretary

First Meeting, May 16, 1922, at 2 p. m.—Presided over by William Ophuls, chairman. First paper by F. R. Nuzum, Santa Barbara, on "The Effect of X-ray Upon the Structure and Bacterial Flora of the Tonsils"; discussed by Von Adeling, Evans and Ophuls. Second paper by R. B. Hill, Los Angeles, "A Clinical and Pathological Study of Fifty Cases of Hyperthyroidism"; discussed by Rusk, Evans, Ophuls and Hill. Third paper by W. T. Cummins, San Francisco, "Germanium Dioxide and Erythropoiesis"; discussed by Wm. Ophuls. Fourth paper by McArthur of Napa, Cal., "Encephalitis Lethargica"; discussed by Hammack, Cummins and McArthur. Ivan C. Hall of Berkeley was unable to present his paper on "Some Limitations on the Agglutination Reaction in the Identification of Sporulating Anaerobes." The chairman appointed a committee, consisting of Evans, Rusk and Hammack, to nominate candidates for Section officers. Meeting adjourned at 4:30 p. m.

Second Meeting, May 17, 1922, 2 p. m.—Wm. Ophuls, chairman, presiding. Committee on nominations reported, nominating Walter Erem, Los Angeles, for chairman, and Roy W. Hammack, Los Angeles, for secretary. These candidates were elected officers of the Section for the coming year. The scientific program consisted of symposium on "Coccidioid Granuloma and Allied Infections." First paper by E. C. Dickson of San Francisco, "A Report of Cases With Especial Reference to Meningeal Involvement." Second paper by G. F. Rusk of San Francisco, "Coccidioides Immitis as a Cause of Meningitis With Hydrocephalus." Third paper by Roy W. Hammack and J. M. Lacey of Los Angeles, "Cases Observed in Southern California."

Fourth paper by N. G. Evans of Loma Linda, "Torula Infection." These papers were discussed by Brem, Taylor, Ophuls, Dickson, Rusk, Hammack and Evans. Meeting adjourned at 4:30 p. m.

SECTION ON TECHNICAL SPECIALTIES

RAY LYMAN WILBUR, Chairman
HAZEL E. FURSCOTT, Acting Secretary

The first meeting of the Technical Specialties Section of the California Medical Society was held at Yosemite, California, May 5, 1922, 2 p. m. The chairman's address brought out the necessity for the general practitioner to be familiar with therapeutic agents other than medicine. The fields of physiotherapy, dietetics, laboratory technique, and social service have been long recognized as specific treatment in the care of the sick, but had become subordinate because of the unfortunately limited connotation of the word medicine. The physician should know how to use and prescribe in these fields, but he cannot be expected to learn all these technical branches. For that reason the technician must be trained. In physiotherapy adequate training is necessary to combat the credulity of the public in chiropractic and other cults. He pointed out the danger of the dietetic fanatic and encouraged the scientifically trained dietitian to supplant the former. The relation of the home and social conditions of the patient he showed to be an important factor in the health program; he urged that the medical social worker be used to meet this need. Charles Pinkham, secretary, Board of Medical Examiners of the State of California, maintained that educated physiotherapists would be the solution of cultism. J. T. Watkins of San Francisco pointed out the dangers of the inadequately trained nurse in physiotherapy; referring to the situation and tendencies in this direction of certain organizations. Langnecker of San Francisco made a plea for the training of physicians to intelligently prescribe physiotherapy. Hazel Furscott emphasized the fact that the nursing profession prefers to keep its identity and is not interested in encroaching on the physiotherapy field except after adequate supplementary training. Edna Shirsper, secretary of the California Association of Medical Social Workers, thanked Dr. Wilbur for his interest in the medical social service and Florence Atkinson expressed the gratitude of the California Association of Physiotherapists. This discussion was followed by a business meeting for the election of officers for the ensuing year. Ray Lyman Wilbur was unanimously re-elected president, and C. LeRoy Lowman of Los Angeles, secretary.

THE CALIFORNIA ASSOCIATION OF PHYSIOTHERAPISTS

HAZEL E. FURSCOTT, President
FLORENCE E. ATKINSON, Secretary

The first annual meeting of the California Association of Physiotherapists was held May 17, 1922, 10 a. m. After preliminary remarks by the president outlining the organization of this association, its activities during the past year, and its plan for future development, Ray Lyman Wilbur, in a thoughtful address on "Educational Standards in Physiotherapy," struck the keynote of the situation in his discussion of the fundamental and technical needs of scientific physiotherapy. The discussants, Morton Gibbons, E. W. Cleary, H. L. Langnecker and J. T. Watkins, felt that Dr. Wilbur had so adequately defined the needs of the situation that they could add nothing but their hearty commendation. The paper by A. W. Hewlett of Lane Hospital on "The Effect of Massage, Heat and Exercise on the Local Circulation," exemplified in detail the necessity for definite scientific research. Spiro in his discussion of Hewlett's paper brought out the point that the feeling of well-being was an important result of stimulation of the circulation. An informal discussion on "Early Physiotherapy Treatment of Fractures," led by Carl Hoag of the University of California Hospital, showed the advantage of different physical therapeutic agents. T. J. Watkins, Gibbons, Kapp, Gottlieb and Mabel Penfield agreed on the general advisability of the procedure. A suggestive point brought out by this discussion was the use of diathermic heat and electric stimulation during the period of immobilization in cast or splint. "The Standardization and Uses of Physiotherapy Equipment" was presented by Mabel Penfield, physiotherapy technician of San Francisco. Her paper contained a fund of detailed information useful to both physician and technician. In the discussion that followed Carl Hoag emphasized the importance of the personality of the physiotherapist over that of apparatus. George Evans of San Francisco stated that physiotherapy was now largely utilized by certain specialties of medicine. He made a plea for the enlargement of the physiotherapy activity to include the patients from all fields of medicine. Other discussants were Kapp and Gottlieb. Hazel E. Furscott, Physiotherapy Department, University of California Hospital, presented a paper on "Physiotherapy Records," illustrated by a complete set of measuring apparatus and lantern slides. The paper showed clearly by these records of progress furnish a definite encouragement of the patient, illustrates the responsibility of the technician to the physician, and establishes the value of physiotherapy records in the advancement of science. At the annual business meet-

ing the following members were present: Hazel E. Furscott, Florence E. Atkinson, Mabel Penfield, Mary Schaaf, Florence Burrell, Sarah R. Davis, Laura McAllister. Acting on ideas for future development of physiotherapy set forth in Dr. Wilbur's address, a resolution was passed unanimously that this association form a committee to draw up a resolution expressing its desire to formulate and conduct an examination for a certificate of approval of this association for trained physiotherapists; the examination to be such as will be approved by a special committee of the State Medical Society, the object being to stimulate proper educational facilities for the training of future physiotherapists.

CALIFORNIA ASSOCIATION OF PHYSIOTHERAPISTS President's Address

HAZEL E. FURSCOTT, San Francisco, California

It is, indeed, a great pleasure to call this first annual meeting of the California Association of Physiotherapists. The association was organized last May for the purpose of establishing and maintaining adequate standards in physiotherapy, and afford the members of the medical profession a group of educated, trained ethical technical assistants. At the present time we have forty-three active members and nine associate members. The most distinctive feature of the past year was a stimulating series of monthly scientific programs. In addition to the contributions by our own members it was our good fortune to have as speakers Doctors Naffziger, Pope, Cleary, Mehrtens, McChesney, Dudley Smith, Markel, Schaller, Tranter, and Hoag.

During the past year many problems have confronted us which we have endeavored to overcome. Outstanding among these were:

First—A gradually decreasing number of educated physiotherapists, due to the lack of adequate educational facilities.

Second—The discrimination in the selection of membership between the educated, trained, physiotherapist and the unethical pretenders.

Third—The need for correlation of existing data and for research.

To meet these needs a survey was planned and workers appointed to gather the necessary information on which to build a foundation for scientific progress.

First—To survey the schools of Europe and America, giving courses in physiotherapy or related subjects.

Second—To survey educational and practical conditions of physiotherapy in the state of California.

Third—To draw up a complete bibliography of physiotherapy literature.

It is the intention of our association to publish this survey when completed.

It would have been impossible to have carried through the past year without the co-operation and assistance of the officers of the Medical Society of California and the League for the Conservation of Public Health.

CALIFORNIA ASSOCIATION OF MEDICAL SOCIAL WORKERS

The first annual meeting was held May 17, 1922. Edna J. Shirsper presided. A paper on "Medical Social Service in the Hospital" was read by Marguerite Wales, director social service, Stanford Hospital. Ray Lyman Wilbur discussed "The Relationship of Social Service to the Medical Profession." "The Place of Medical Social Service in Hospital Organization and the Duties of Medical Social Workers Toward Hospital Administration" was the subject of a paper by Frank R. Nuzum, Cottage Hospital, Santa Barbara. The important subject of "Social and Economic Diagnosis" was discussed by C. H. Arnold, Stanford Hospital; F. R. Nuzum, Santa Barbara; Alvin Powell, Oakland; T. C. Lyster, Los Angeles; E. W. Hodgdon, Jr., Pasadena; Mrs. McManus, State Board of Health, and Marguerite Johnson, Telegraph Hill Clinic, San Francisco. At the business meeting Marguerite Wales was elected president, Josephine Abraham vice-president, Edna J. Shirsper secretary and treasurer for the ensuing year. The following directors were elected: Lillie Lindsay, Regina Horton, Eleanor Stockton and Rose Steinhart.

Stanford Establishes Course of Instruction for Physiotherapists—There has recently been instituted in Stanford University Hospital, a course of study for the training of technicians in physiotherapy. This course is designed to give adequate theoretical and practical knowledge to those persons who want to have efficient training in this branch of medical treatment carried on under the supervision of the medical profession. It is also open to members of the medical profession who may be interested in acquiring familiarity with the methods and results of the various forms of physiotherapy. The course has been instituted to meet a strong demand for wider universal knowledge of physiotherapy in its application to rehabilitation and industrial accident work.

COUNTY NEWS

ALAMEDA COUNTY

Alameda County Medical Association (reported by C. L. McVey, secretary)—The general meeting of the Alameda County Medical Association was held on June 19 at the Public Health Center.

S. Everingham read a paper, "Fractures—Their Early Treatment." P. F. Abbott presented a case of Mikulicz's Disease. W. A. Wood and Ann Martin discussed the following subjects, "Clinical Importance of the Schick Test. Toxin, Anti-Toxin Treatment." The Ethel Moore Memorial Building of the Alameda County Health Center will be completed about August 1, 1922.

New Maternity Department for Fabiola Hospital—According to Mrs. J. P. H. Dunn, president of the Fabiola Hospital Association, a contract has been let for a new maternity department for Fabiola Hospital to cost \$200,000. The maternity department is to be modern and complete in every respect and is to have fifty beds.

\$700,000 Hospital for Oakland—The Providence Hospital Association has purchased the Bancroft Block in Oakland and the Sisters of Providence Hospital announce that they hope to begin the erection of the new \$700,000 building this year. Nineteen years ago the Sisters of Providence Hospital Association came to Oakland and they have operated the present hospital since that date. Providence Hospital of Oakland is one of a chain of hospitals, extending through Canada, the Northwest, and south to Oakland, California. The Mother General is at the head of the main hospital in Montreal, Canada.

BUTTE COUNTY

Enloe Hospital, Chico—Dr. N. T. Enloe has again assumed charge of the management of the Enloe Hospital. Dr. N. T. Enloe, Jr., who has been managing the hospital for the past year, is devoting his entire time to the automobile business.

FRESNO COUNTY

Fresno County Hospital Accredited by Council on Education and Hospitals of A. M. A.—The Fresno County Hospital has been accredited for the instruction of intern in a letter of June 17 to Dr. H. O. Collins, director of the hospital. The letter reads in part as follows:

"We are sure that you realize how much we are interested in the good work which the hospital is doing. It has been a pleasure to note from time to time the really important strides which have been made within the last few years as they have come to our attention from you directly and especially through the very thorough and conscientious work of Dr. Musgrave.

"Along with our recognition of your hospital on our list of hospitals approved for internship there is an interest that will not be in any sense abated, and I assure you that the future progress of your hospital will be a matter of great interest to us and I hope to hear from you from time to time."

This accredited standing was made upon the recommendation of the Council's committee in California, which is the section on Medical Economics, Education and Hospitals on the League for the Conservation of Public Health.

Dinuba Sanitarium Sold—H. T. Haden has purchased the property of the Dinuba Sanitarium from Charles Weddel for \$30,000.

Selma Sanitarium Now Open For Patients—A

new sanitarium at Selma has at last been finished and is now operating. The Board of Directors are: O. W. Steinwand, secretary; Mrs. Maude Scott, treasurer; C. W. Christenson, J. P. Olsen and P. H. Hansen.

KERN COUNTY

Jefferson Hospital—Drs. Hawkins and Edgerton have opened a new hospital of twenty beds in Taft at Fourth and Lucard streets. Miss Nan Rector is superintendent of this new hospital. The basement of the building contains the nurses' quarters, kitchens, storerooms, etc., while the main floor is given over to patients' beds and office space. Drs. Hawkins and Edgerton state that their hospital is open to all physicians upon equal terms.

Kern County Hospital—It is reported that the Board of Supervisors of Kern County have purchased a site for the new County Hospital. Plans for the hospital, which with the new juvenile home and home for indigents will cost approximately \$400,000, are now being drawn.

LOS ANGELES COUNTY

Barlow Sanitarium Receives Bequest—By the terms of the will of Mrs. Lucia W. Jennison of Covina, the Barlow Sanitarium was left a \$5000 bequest as a memorial to her husband and son.

Golden State Hospital—J. Rollin French and C. E. Early operate this hospital in connection with their industrial, surgical and restoration institution. According to the Los Angeles Express this hospital has recently been very much enlarged and improved in many ways.

Hollywood Hospital—Architect Robert H. Orr has been commissioned to prepare plans for the new Hollywood hospital to be located on Vermont avenue near Sunset Boulevard. The Hollywood building is to be four stories and basement, covering an area of 8700 square feet.

Municipal Hospital for Long Beach—A meeting was held on July 11 of all persons interested in hospital work for the city of Long Beach. Long Beach has recently voted a bond issue authorizing the city to construct a hospital. Councilman Fillmore Condit, head of the City Hospital Committee, presided.

Ministers of Long Beach Request Service for Sick at Cost—A Long Beach Ministerial Union recently passed the following resolution:

"Whereas, It is customary in most Christian communities to provide hospital facilities for the sick and injured on a non-profit basis; and

"Whereas, A movement is on foot in Long Beach to make such a provision possible in this community;

"Resolved, that the Ministerial Union of Long Beach appeals to the Seaside Hospital Association to lead in the organization of a community hospital association upon a non-profit dividend basis to serve the interests of our city under a just and equitable recognition of the rights of the present owners of the Seaside Hospital property."

Harbor Hospital Association of San Pedro—The physicians of San Pedro are making an effort to build and operate a satisfactory hospital at San Pedro. Over \$50,000 has already been subscribed and the association has \$21,000 on deposit. The site has been purchased at Tenth and Meyler streets and the foundations are already under construction. The present board of directors is made up largely of Long Beach and Los Angeles stockholders. These stockholders have expressed their willingness to turn over to the San Pedro physicians their holdings as well as the management of the institution wherever San Pedro physicians are in a

position to accept the responsibilities. Dr. Rodgers of San Pedro is taking a leading part in the activities of this hospital.

Murphy Memorial Hospital—The Forum Club of Whittier recently held a meeting to discuss the future of the Murphy Memorial Hospital. This hospital, originally constructed by Colonel Murphy, was donated to the municipality of Whittier under certain conditions.

Permanent Quarters—Harlan Shoemaker, secretary of the Los Angeles County Medical Society, reports progress with their permanent building fund. This is a most worthy movement which should have the endorsement and support of all members.

Barlow Library Notes—Barlow Library is maintained by the medical profession. Our own people pay the bills! You are welcome to use it, without money and without price. But a ten-dollar or a twenty-five-dollar membership is appreciated. If you wish to become a member send your check to the librarian, and watch the results. Try it once, anyway.—(L. A. Med. Soc. Bulletin.)

Cottage Hospital, Burbank—Miss Cecil Williams, former owner of the Cottage Hospital, has sold it to Miss Grady Weems, Miss F. Short and Miss Beulah Newton. Miss Weems is the superintendent, Miss Short will be in charge of the surgical department and Miss Newton will act as superintendent of nurses.

Lamanda Park Hospital—Dr. J. B. Keaster has purchased the property at 2563 East Colorado St., and is converting the present building into a hospital of which he is the owner and director.

New Hospital for Torrance—A bequest of \$100,000 was left in the will of the late Mr. Torrance for the erection of a hospital at Torrance, the town which he founded. The details of the bequest have not yet been made public.

Additions to St. Vincent's Hospital—The Sisters have decided to build an annex to cost \$300,000 to St. Vincent's Hospital. Mr. J. S. Austin, architect, states that the annex will be eight stories high and contain one hundred beds.

Culver City Hospital—F. M. Hull, M.D., will shortly erect a five-bed hospital on Putnam avenue. The new hospital will be provided with laboratory and X-ray equipment.

MARIN COUNTY

Marin County Medical Society (reported by Chester A. De Lancey, secretary)—At the last meeting of the Marin County Medical Society it was voted to take under consideration the questionnaire concerning industrial medicine. This action was taken in order to gain further information on this subject which it is expected will appear in an article in the State Journal of Medicine.

Arthur Mays, who was a delegate to the State convention, gave an interesting account to a special meeting of the society of the different meetings at Yosemite.

Hans Lissner of San Francisco favored the society with an address on Endocrinology. He pointed out that pluriglandular therapy is useful only when constructed on monoglandular therapy in given individual cases. He also pointed out the necessity of telling patients at the outset that glandular therapy extends over many months. Many new and interesting points on endocrinology were presented to the society.

San Rafael Cottage Hospital—The San Rafael Cottage Hospital is reported to be installing a delivery room for the maternity department.

MONTEREY COUNTY

Monterey Sanitarium—Dr. Martin McAulay has converted the old Governor Pacheco adobe residence into a hospital, equipped with operating room, X-ray and other departments.

NAPA COUNTY

Walter Springs Health Resort Sold—The Walter Springs Health Resort, controlling the output of the Walter Springs Water, has been sold to Mr. Van Hovenberg of San Francisco. Mr. Van Hovenberg proposes to make this one of the attractive resorts of California.

ORANGE COUNTY

Orange County Medical Society (reported by Rowland P. Yeagle, secretary)—At the regular meeting of the society for April, held in Santa Ana, the following officers were elected for the ensuing year: President, James C. Crawford, Orange; vice-president, Bessica F. Raiche, Anaheim; treasurer, William C. Duboid, Santa Ana; secretary, Rowland P. Yeagle, Santa Ana; librarian, John Wehrly, Santa Ana; board of councilors, J. H. Lang, Fullerton, G. A. Shank, Huntington Beach, C. D. Ball, Santa Ana.

Orange County Hospital To Have Addition—Plans are under way to build a psychopathic ward in connection with the Orange County Hospital. The new addition will cost \$28,000. H. E. Zaiser, M. D., director of the hospital, states that the new department will be made as free from any appearance of restriction as it is possible to make it. A courtroom will be provided in connection with the addition.

PLACER COUNTY

Placer County Medical Society (reported by Robert A. Peers, secretary)—The Placer County Medical Society met in Auburn, at the Masonic Temple, July 8, 1922. Charles J. Durand, the president of the society, occupied the chair. The following members and visitors were present: Members—Drs. Durand, Miner, Peers, Rooney, Mackay, Fay, Talbot, Horne and Russell. Visitors—Wiltse, Auburn; Kanner, Colfax; Whittington, Weimar; Ward, Auburn.

H. M. Kanner of Colfax, Dwight Davis Johnson of Grass Valley and William L. Whittington of Weimar, a member of the Alameda County Medical Society, were elected to membership in the society.

The following members were endorsed for industrial insurance work—W. P. Sawyer, Nevada City; J. Gordon Mackay, Auburn; J. A. Russell, Auburn; William A. Lavery, Loyalton; George Howard Fay, Auburn; A. H. Tickell, Nevada City; E. R. Brooks, Floriston; Frank Lisle Horne, Auburn; Earl E. Ostrum, Loomis; J. Suley Wheeler, Lincoln.

Case reports were made by the following members: Miner, Kanner, Mackay, Talbot, Rooney, Peers and Whittington.

Robert F. Rooney of Auburn read the paper of the evening entitled "Over Fifty Years in Medicine," in which he traced the history of medical discoveries during his fifty-two years of practice. The doctor also spoke of his many personal experiences during this time. He also paid his respects to the various cults and fads of that period. He finished by reciting a poem, written by himself, entitled "The Old Practitioner." Rooney's paper was enthusiastically received and was discussed by all those present. The remainder of the evening was spent in reminiscences.

PLUMAS COUNTY

New Sanitarium at Quincy—Dr. W. W. Peterson is constructing a sanitarium at Quincy. Dr. Peterson will have charge of the Feather River Lumber Producers' Association practice.

RIVERSIDE COUNTY

Riverside Community Hospital, Election of Board of Directors—At the annual meeting of the Riverside Community Hospital Association the following directors were elected for the ensuing

year: W. B. Clancy, Mrs. George Cole, E. M. Doyle, Lyman Evans, S. C. Evans, T. F. Flaherty, J. T. Garner, Stanley F. Henshaw, Rev. R. A. Kirchoffer, Alfred M. Lewis, Frank A. Miller, F. T. Morrison, Mrs. Julia Moulton, Mrs. A. N. Sweet, A. B. West. The annual report of the Secretary showed the subscriptions towards the new hospital \$189,519.26, subscribed by 2,314 persons.

New Medical Director of the Riverside County Hospital—Dr. W. A. Jones of Arlington has been appointed. Dr. E. H. Wood, former director, has had to give up the work for the present on account of ill health. Miss Jessie Twogood will continue to act as head nurse and Mrs. Margaret Carroll as housekeeper and business manager.

Hillcrest Hospital Has New Director—Dr. J. A. Ramsay will be general manager and chief physician to Hillcrest Hospital, Hemet. Dr. Gregory, former director of the hospital, has retired from its active management.

SACRAMENTO COUNTY

Sutter Hospital—I. W. James, M. D., Secretary of the Board of Directors, announces that the contract for the construction of the new Sutter Hospital has been awarded to George Wagner of San Francisco. The hospital is to be located on L Street between Twenty-eighth and Twenty-ninth Streets.

SAN BERNARDINO COUNTY

Upland Hospital (Paul Memorial Hospital)—At the annual meeting of the board of directors of this hospital held recently, E. W. Paul was elected president; E. H. Richardson, vice-president; Thomas W. Nisbet, secretary; Harold C. Moore, treasurer. Other directors are: Dr. W. H. Craig, Mrs. James L. Paul, G. A. Hanson, W. K. Beattie, Dr. J. H. Titus and A. H. Johnson. Plans for this new hospital, which is to cost \$110,000, have at last been approved, and there is a campaign on at the present time to increase the funds on hand sufficiently to open the institution without debt.

SAN DIEGO COUNTY

San Diego County Medical Society (reported by Robert Pollock)—The San Diego County Society will hold no scientific sessions during July and August. It plans to promote goodfellowship preliminary to the fall sessions by holding a picnic for the members and their families late in August. The prevailing epidemic in San Diego and vicinity at present seems to be acute polydipsic golfitis. No fatalities have as yet been reported, although restrictive measures are contemplated by the authorities. The County Society tendered a banquet to Ernest Fuchs of Vienna during his brief stay in San Diego while enroute to San Francisco, where he delivers a course of lectures on ophthalmology. Dr. Fuchs' address was replete with practical diagnostic points related to every-day eye conditions that confront the general practitioner.

Alpine Sanitarium Under New Management—Paul M. Carrington, M. D., has taken over the management of the Alpine Sanitarium at Alpine, San Diego County, and will continue it as an open-staff hospital. Its location admirably fits it for the treatment of the tuberculous and asthmatic as well as those suffering from nervous and nutritional disorders.

Addition to Paradise Valley Sanitarium—About 500 people attended the laying of the cornerstone of a new 50-bed addition to the Paradise Valley Sanitarium at National City on the afternoon of July 2. The exercises were presided over by Alton D. Butterfield, medical director of the institution, and the address of the day was delivered by Percy T. Magan of Los Angeles, member of

the hospital betterment committee of the League for the Conservation of Public Health for Southern California. The new building will be of fireproof construction, and will be devoted to surgery and obstetrics.

Proposed Escondido Cancer Hospital—It is reported that Dr. L. T. A. Hotten of Escondido has asked permission of the city trustees to solicit funds to build and operate a cancer hospital at Escondido. It is further reported that the board referred the matter to Dr. Lorini, Health Officer, for recommendation, and that Dr. Lorini gave his consent for the soliciting of funds for the hospital from the public.

SAN FRANCISCO COUNTY

San Francisco Board of Health Replies to Criticism of the San Francisco Hospital—The Board of Health takes exception to the reported statement of the foreman of the grand jury that "deplorable conditions" exist at the San Francisco Hospital and that "poor patients are miserably treated." In an open letter, President Barendt says:

"In a large institution such as the hospital, there cannot help but be occasional infractions of the rules by some of the employees, visiting or attendant physicians, but to condemn an entire institution for the infraction of a rule shows the utter unfitness of the critic in this case to occupy the position which he does.

"I have been unable to find that any of the grand jury for whom Jungblut professes to speak have visited the hospital or have mentioned to anybody in what the 'deplorable state of affairs' consists.

"I have only to invite the members of the grand jury to visit the hospital whenever they please and—with due regard to the feelings of the patients—to make their rounds wholly unattended and to investigate it from garret to basement."

SANTA BARBARA COUNTY

Celite Hospital Destroyed by Fire—On May 25, at one o'clock in the morning, Celite Hospital at Lompoc was discovered to be on fire and very quickly burned. No lives were lost. Mr. Smith, the superintendent, states that it will be reconstructed.

SANTA CLARA COUNTY

East Columbia Hospital, San Jose, Has New Director—Dr. Frank H. Paterson has turned the management of the East Columbia Hospital over to H. D. Jenkins. According to newspaper dispatches Jenkins plans to make a number of improvements in the physical plant and is quoted as saying that the future of the hospital is to be built upon two words, "service" and "business."

San Jose Physicians Form Luncheon Club—The physicians of San Jose have formed a luncheon club to meet every Tuesday. H. C. Brown is president and R. S. Kneeshaw secretary of the club. It is proposed to have prominent guests attend as many as possible of these meetings, to discuss matters of interest to physicians.

SISKIYOU COUNTY

Siskiyou County Abandons Plan for County Hospital—Supervisors of Siskiyou County had plans well under way for construction of a \$200,000 hospital, to be located at Yreka. A delegation of taxpayers appeared before the supervisors to demand that all plans be abandoned. The supervisors decided to do so for the present.

SOLANO COUNTY

Vallejo General Hospital—This new hospital is located at the corner of Tennessee and Sutter Streets in Vallejo and is now open for patients.

SONOMA COUNTY

Sonoma County Hospital—Plans are under way for the erection of a department to the Sonoma County Hospital for the care of patients suffering from tuberculosis. The plans were advanced at a meeting held in the offices of Dr. P. A. Meneray for the discussion of problems connected with this work.

Hillside Hospital—This Hospital, located at Petaluma, has been sold to Carl Haderman, who will take immediate possession. Mrs. Johanna Petersen will be superintendent. Mr. Haderman states that he will continue to run the hospital as a first-class institution.

STANISLAUS COUNTY

Oakdale Hospital—The municipal board of trustees of the proposed Oakdale Hospital has been organized. The directors are: E. T. Gobin as president of the board and R. L. Acker as secretary; the other members are A. L. Gilbert, Mary Roberts, Ed Rodden, Mary Lambuth, W. A. Patterson and L. C. Kaufman. The board decided to build a sixteen to twenty-bed hospital, two stories high, at a cost not to exceed \$30,000 for building and equipment.

Temporary Hospital—Physicians of Oakdale have joined in establishing a temporary hospital in a home, pending the completion of the proposed municipal hospital. The dwelling being used for temporary purposes is being improved and will take care of five patients when ready for occupancy.

TULARE COUNTY

Instructions for Mothers in Hygiene at Dinuba—Newspapers report that the Dinuba Chapter of the Red Cross, under the leadership of one of their school nurses, is planning to give a course of instruction in hygiene to the mothers of Dinuba. Mothers who take 18 hours of the instruction will be given a certificate.

VENTURA COUNTY

St. John's Hospital Organizes a Staff—The staff of St. John's Hospital, Oxnard, has been organized, with the following officers: John G. Norman, president, and Raymond T. Francis vice-president and secretary. The staff is to meet once a month.

YOLO COUNTY

Tuberculosis Survey in Yolo County—It is reported that a public health nurse is arranging for a tuberculosis survey of Yolo County and that she will call in expert assistance from outside to assist her in making examinations and tests. According to newspaper reports, the object is not so much to acquire statistics as it is "to assist those who are tubercular or showing signs of the dread disease in combating it in its early stages."

Is it possible that the physicians of Yolo County are not essential in making diagnoses or giving treatment to tuberculous patients in that county?

Printer Was Peeved—A printer in Fort Worth, Texas, got slightly peeved at a letter from a doctor who wanted bids on several thousand letterheads, different sizes, different grades, and different colors, and wanted the printing form held standing. So he took his typewriter in hand and wrote:

"Am in the market for bids for one operation for appendicitis. One, two or five-inch incision—with or without ether—also with or without nurse. If appendix is found to be sound, want quotation to include putting same back and cancel order. If removed successfully, bidder is expected to hold incision open for about 60 days, as I expect to be in the market for an operation for gallstones at that time and want to save the extra cost of cutting."—Kansas City Post.

SOME GOOD LEGAL ADVICE

Mr. George W. Whiteside, attorney N. Y. Medical Society, in New York Medical Journal, offers some good legal advice to physicians:

"Use X-ray in diagnosis of all fractures and dislocations both before and after the fracture or dislocation is reduced. The X-ray plate provides a permanent record of the condition and reduces the element of possible fraud upon the physician. In orthopedic work often ordinary photographs of conditions that would not be indicated by the X-ray are likewise of value.

"Where a physician is dismissed from a case, a letter to the patient, the physician retaining a carbon copy, fixing the time and circumstances, might prevent a future claim by the patient that the physician abandoned the case. This claim by patients has arisen in a number of cases, where the true facts clearly indicated that the physician was dismissed and another physician employed.

"In cases of children particularly, although clinical diagnosis may not indicate diphtheria cultures from the nose and throat should early be taken. Suits have been based upon the claim that such cultures were not taken, where fortunately the physician was able to show from the records of the Department of Health the taking of such cultures.

"Where diphtheria is present in one child in a family, similar cultures may well be made of the other children and members of the family. This practice should at least be advised by the physician to the family, and while of doubtless benefit to the family as a precautionary measure, may eliminate and prevent the probability of claims against a physician.

"The early use of antitoxin in all diphtheria cases in doses suggested by the health authorities is recommended.

"Where intubation is necessary, insist that the patient be in charge of a nurse competent to act when conditions indicate the necessity of reintubation, so that intubationists may be summoned promptly. In the absence of such expert nurse advise hospital treatment.

"Advise either patient or family of the probable outcome of disease or operation where feasible. This may avoid claims against a physician where unsatisfactory results are inevitable in the nature of the case, but, through patient's ignorance or otherwise, claims against a physician are made.

"Time and frequency of visitation to sick patients in serious cases should be determined by the physician and not by the family. A doctor's desire to save a patient expense may be considerate for the patient's purse, but may be hazardous to the doctor if subsequent claim of neglect of the case is made.

"Keep records of every patient treated so that the transaction may be identified. Records made at the time of treatment may be invaluable to the physician in establishing the falsity of the claim made against him."

Resolution Disapproving the Public Health Activities of the Red Cross—"We approve the recommendation of the Board of Trustees relative to the Public Health activities of the American Red Cross, and their advice that the House of Delegates take appropriate action to convince those in authority that the public health activities of this organization are no longer necessary, and if continued are likely to promote community irresponsibility and helplessness in regard to its own welfare.

"Your committee further recommends that the Board of Trustees take such action as will make this recommendation effective at the earliest possible moment."—Abstract from Minutes of the Seventy-Third Annual Session of the A. M. A.

BOOKS RECEIVED

Transactions of the American Pediatric Society. Thirty-third session. Held at Swampscott, Mass., June, 1921. Edited by Joseph Brennenmann, M. D.

Applied Chemistry. An elementary text book for secondary schools. By Fredus N. Peters, Ph. D., Instructor in Chemistry in Central High School, Kansas City, Mo., for twenty-three years; more recently vice-principal. Author of "Chemistry for Nurses," etc. Illustrated. St. Louis. C. V. Mosby Company, 1922. Price, \$3.50.

Symptoms of Visceral Disease. A study of the vegetative nervous system in its relationship to clinical medicine. By Francis Marion Pottenger, A. M., M. D., LL. D., F. A. C. P., Medical Director Pottenger Sanitarium for Diseases of the Lungs and Throat, Monrovia, California. Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasms and Degeneration," etc. Second edition. With 86 test illustrations and 10 color plates. St. Louis, C. V. Mosby Company, 1922. Price, \$5.50.

The Healthy Baby. The Care and feeding of infants in sickness and health. By Roger H. Dennett, B. S., M. D., Professor of Diseases of Children and Director of the Department in the New York Post-Graduate Medical School; attending physician in the Babies' Ward of the New York Post-Graduate Hospital; Consulting Pediatrician to the Victory Memorial Hospital, Brooklyn, the Passaic General Hospital, the New York Episcopal Orphans' Home and Asylum, etc.; Fellow of the New York Academy of Medicine. Second edition, revised. New York, the MacMillan Company, 1922. All rights reserved.

BOOK REVIEWS

Diseases of the Eye. A handbook of ophthalmic practice for students and practitioners. By George E. de Schweinitz, M. D., LL. D. Ninth edition, reset, with 415 illustrations and seven colored plates. Philadelphia and London: W. B. Saunders Company, 1921.

Many new subjects, including new operative procedures, make their first appearance in this edition. This standard textbook reflects the present state of the knowledge and the literature of ophthalmology. F. C. C.

Diseases of the Skin and the Eruptive Fevers. By Jay F. Schamberg, M. D., Professor of Dermatology and Syphilis, Graduate School of Medicine, University of Pennsylvania. Fourth edition thoroughly revised. Octavo of 626 pages, 265 illustrations. Philadelphia and London: W. B. Saunders Company, 1921. Cloth, \$5 net.

This book is well worth the room and its purchase price. The discussions on syphilis and the eruptive fevers particularly are diagnostic and among the best. The book contains many excellent prescriptions.

In most of the ordinary skin diseases the descriptions are quite concise and well worth reading. The reviewer recommends the book. G. D. C.

Opportunities for Malpractice Suits—"A suit for malpractice may be based on acts of omission as well as commission, and a physician may be sued for failing to do something he should have done as well as for doing something he should not have done. Another definition says, "Malpractice is the treatment of a patient by a physician or surgeon in a manner contrary to accepted rules and with injurious results to the patient." Every courageous physician who advances further than the accepted rules permit may lay himself liable to a charge of malpractice.

It is definitely known that in a large majority of the malpractice suits the patient was unable to and did not pay for the services rendered by the physician. The reasons why charity patients are more prone to bring malpractice suits are, first, these patients are notoriously careless and indifferent about following the advice and instruction of the medical attendant; and second, they always need the money. They are just as careless about following instructions regarding a fracture as they are about their financial affairs and, therefore, they are more likely to get a bad result. Because they always need money they are usually willing to sue a physician, or anyone else for that matter, if there is even a faint chance to obtain money.

Young impecunious lawyers are frequently a cause of malpractice suits. The old-established lawyer of good reputation very seldom appears for the plaintiff in a malpractice suit against a physician. He has acquired a wholesome respect for the medical profession and his observation has taught him that it is very seldom that a medical practitioner is actually guilty of malpractice.

I have known of a few suits that were brought because of the jealousy and meanness of a rival practitioner of medicine. Of all asinine, stupid ways of getting revenge, the instigating of a malpractice suit is the meanest. If the suit is successful it will probably encourage others, and the star medical witness for the plaintiff is likely to be the defendant in the next case."—Illinois Medical Journal, June, 1922.

The Cost of Medical Insurance in England—Sir J. D. Rees, M. P., recently stated "that the expenditure in this connection had risen from twenty-five millions sterling in 1890-91 to three hundred and thirty-two millions in 1920-21 and would probably be not less than four hundred millions for 1921-22. He developed the fact that thirty million persons, exclusive of unemployed, out of a population of forty-eight millions, had been in receipt of public assistance in 1919-20. . . . Mr. Macquisten pictured the application of the principle of the National Insurance Act to the legal profession and said that he imagined that if the public were required to 'hand over so much a week to the barrister for the purpose of getting advice, the legal advice obtained in such circumstances would be the same kind of advice as the medical advice given by the panel doctor.' This member evidently does not think very highly of the panel doctor nor of the act, which he said provided doctors who could not get practices in the ordinary competition in the medical profession and is carried on by inflicting penalties upon very poor people who can get no benefit from it. . . . An inquiry in Parliament, by Sir J. D. Rees, brought out the fact that the total charge upon the Government for health insurance in 1920-21 was approximately nine and one-half pounds and for 1921-22 estimated at nine million pounds. The contributions of employers and employed in 1920-21 were approximately twenty-one million four hundred thousand pounds, and estimated for 1921-22 at two hundred thousand pounds more than in the preceding year."

REFLECTIONS ON MEDICAL ETHICS

"Since nation-wide publicity, reaching to every obscure crossroads newspaper in the land, has been given to a speech delivered a few days ago by that otherwise useful man, Royal S. Copeland, reflecting on Medical Ethics, it is time for the profession to take notice. . . . When a man like Copeland gives voice to such statements as 'the Code of Medical Ethics is the most antiquated, moss covered germ laden institution in the world' . . . by his own language convicts himself of what it is charity to ascribe to simple ignorance on the part of its author. . . .

"No! the most emphatic tenets of medical ethics have always been to gladly and freely hand to humanity whatever has been discovered for the alleviation or cure of diseases and to condemn, as despicable quacks, all 'who make a secret of cures.' . . .

"Heritages from the wise, as well as the written evidences of lofty ideals from our profession, who during the ages have held aloft the Caduceus of Hermes, are sometimes overlooked in the cares and drudgery of professional life. Some, therefore, are to be found with heads more or less burdened with scientific acumen who show unpardonable ignorance of their duty to the community and to the profession to which they belong. Such one-sided tendencies can but be deplored. . . .

"The lamented Dr. Osler said in reference to the public: 'There is a delightful Arabian proverb, two lines of which run: "He that knows not and knows not that he knows not is a fool—shun him. He that knows not and knows that he knows not is simple—teach him." It is our province to have to deal with the extremes of civic life. We must fight the wilful ignorance of the other. Not with the sword of righteous indignation, but with the skilful weapon of the tongue. On this ignorance the charlatan and the quack live.' . . . It is unprofessional and ignoble to fail to defend the reputation of an absent brother when justice demands it—well has it been observed: 'He who degrades a colleague degrades his art.' . . .

"In changing from one physician to another it is common for patients to attempt to justify their course by speaking ill of the former physician. No physician should permit such criticism. . . .

"The porcupine attitude towards other physicians and petty quibbling only furnish material for jocose remarks from the public and add nothing to a vocation which holds a sacred trust. . . . Disparaging allusion to the ignorance of the past does not commend one, for the world knows centuries were required to produce one Hypocrates, a Jenner, a Pasteur and a Sims, not to mention a few great now living, and that the vaunted perfections of today will be viewed by the medicine of the future much as we contemplate prehistoric man's stone ax. . . . From the physician the public has a right to exact efficiency in diagnosis, treatment, and prophylaxis. To meet these requirements every available aid must be invoked to properly interpret the intricate symptoms at times encountered, not forgetting that abstract science is nothing unless it be the handmaiden to an analytical mind, common sense and sound judgment. . . . The crucial test for all conduct—the one law, which, regardless of creed or religion, all philosophers and prophets acknowledge as paramount in determining and governing human relationships from a social or economical viewpoint—is the Golden Rule. Make it the standard of measurement for every act; the court of last resort—the final tribunal for every doubtful position, and error will not occur."—Furman, *Southern Medicine and Surgery*, June, 1922.

GENIUS AT BAY

"If genius is a neurosis, as has been plausibly argued, then some interesting questions may be postulated in the light of new knowledge in the psychologic sphere. . . .

"Hitherto, the genius either did not know that there was anything the matter with him, or if he suspected that there was he had no idea as to its nature. Other people said that his gifts were from God—or from the devil. But nowadays we account for him with equal glibness, in another way; we say that he is a neurotic, and we furnish him with a set of Freudian complexes that would put an Oedipus to shame. . . .

"Now we don't believe that geniuses of an older day tried to understand themselves; they just pegged away at their marvelous creations and made the most of life without inquiring too closely into the reasons why of their unconventional activities; and it wouldn't have done them any good if they had, for men had not then gone beyond God and the devil in their thinking; Freud was born late, and our ancient geniuses were deprived, as it were, of his services. . . .

"The point to which we are leading up is this: The genius of today can hardly escape 'contamination' by the Freudian lore which drips from everybody's tongue and pen. Will it not prove to be a tanglefoot influence? When your genius becomes self-conscious and censorious about his mechanisms will he not cease to be an honest-to-goodness genius? How can a potential Shelley, wrastlin' with something on the Skylark order, forget his complexes long enough to turn out an ode of immortal quality? Let us suppose that he starts in with an inspired line or two comparable to those with which Keats begins the Grecian Urn; at that point Keats was no longer a man, but a veritable god; at that same point our present-day genius will realize that it is only some darned homosexual complex that is attempting to order his fancies and he will not be able to capitulate to it quite completely enough to give us another Grecian Urn? . . .

"That is the point. How can there ever be another Grecian Urn? . . .

"This Freudian stuff defeats that which it attempts to elucidate. It is a Frankenstein. It hampers the divine fermentation that begets great art. . . .

"Suppose that Leonardo da Vinci had understood that his mother-love complex was at the bottom of all his extraordinary mechanisms, and suppose that he had realized all the morbidity and abnormality of his obsession—is it likely that he would have yielded to it so completely as to achieve all that we know as the product of his brain and hand? Do not such things depend, after all, upon one's sublime unconsciousness of the workings of creative mechanisms? . . .

"Truly our civilization seems to carry within itself all the germs making for its own destruction. . . .

"Today we understand the reasons for everything—which may be why we are at such a standstill in the world of art. . . .

"It would require a genius to show us the way out of such a dilemma. How can the *reductio ad absurdum* be escaped?"—(New York Medical Journal, July, 1922.)

Sheppard-Towner Act Rejected—The Legislatures of Massachusetts and New York and Rhode Island have recently rejected Federal aid as offered through the provisions of the Sheppard-Towner act. New York has appropriated \$130,000 for "protection of the health of mothers, infants and children" to be expended by their own Board of Health. . . .

NEW MEMBERS

H. B. Farnsworth, Oakland; Wm. G. Morton, Needles; F. Wm. Gardner, Loma Linda; E. W. Weirich, Angels Camp; James D. Coyle, Sacramento; H. A. Clattenburg, Folsom; David Cohn, San Francisco; Hiram B. Duncan, San Francisco; Llewellyn L. Jones, San Francisco; Delta R. Olsen, San Francisco; Clifton A. Thomas, San Francisco; Percy A. Millar, San Francisco; Jos. A. Sampson, San Francisco; John D. Humber, San Francisco; Thos. H. Kelly, San Francisco; N. T. McArthur, Imola; H. R. Coleman, Napa; Francis E. Morgan, Santa Cruz; Dexter N. Richards, Berkeley; Edgar D. Smith, Los Olivos; Amy C. Stevens, San Francisco; Robin L. Richards, San Francisco; John E. Wilson, Los Angeles; R. Umeswa, Los Angeles; Homer S. Wilson, Lankershim; James Johnston, Los Angeles; Florence Keller, Los Angeles; C. F. Harding, Ocean Park; A. V. Stephenson, Long Beach; Frank H. Chase, Los Angeles; Albert Q. Spaulding, Santa Barbara; Jesse C. Edwards, Oakland; Walter W. Peterson, Weaverville; Melvin J. Rowe, Talmage; John N. Blood, Exeter; Keith S. McKee, Bakersfield; Wm. H. Moore, Bakersfield; Wm. O. Moore, Napa; Edward W. Beach, Sacramento; Leo P. Bell, Sacramento; Morris H. Silverberg, San Francisco; Geo. E. Sutton, San Francisco; W. H. Bucher, San Fernando; Raymond C. Thompson, Whittier; Steele F. Stewart, Los Angeles; D. E. Goodwin, Long Beach; Clarence S. Cook, Los Angeles; James McC. Stoddard, Beverly Hills; Herman E. Schorr, Los Angeles; Lawrence Downs, Los Angeles; Carl T. Rose, Los Angeles; R. L. Thompson, Burbank; Louis D. Cheney, Los Angeles; John F. McKittrick, Los Angeles; W. H. C. Hatteroth, Oakland; A. A. McClurkin, Fortuna; John D. Lawson, Woodland; Thos. M. Cunningham, La Mesa; H. W. Pasley, Del Rey; Albert F. Goldberg, Fresno; W. G. Milholland, Fresno; Alson R. Shufelt, San Jose; J. W. Green, Vallejo; Hugh E. Smith, Newman; Smith A. Quimby, Madera; T. Victor Hammond, San Francisco; Carol O. E. Werner, San Francisco; Edw. F. Stadtherr, San Francisco; D. M. Ervin, San Francisco; Paul Weinholz, San Francisco; Frank Y. Kitsuda, San Francisco; F. Vowinkel, Alameda; Henry G. Zanger, San Francisco; Merton J. Price, San Francisco; Theo. Kryshtovich, Los Angeles; Arthur L. Gagnon, San Diego; W. F. Pritchard, Imola; Herbert R. Stolz, Sacramento; Wm. E. Costolow, Los Angeles; Herbert C. Jones, Pasadena; Charles Stein, Bellflower; M. M. T. de Gerin, Los Angeles; Donald McGibbon, Los Angeles; W. H. Buskirk, Los Angeles; O. B. Sheets, Los Angeles; John C. Rogers, Long Beach; James F. Percy, San Diego; A. S. Abdum-Nur, Los Angeles; Wm. Cole, Anaheim; Augustus H. Galvin, Anaheim; John B. Legnard, San Diego; Lillian B. Mahan, San Diego; S. K. Jamgotchian, Fresno; Florilla M. White, Palm Springs; Rodney A. Yoell, San Francisco; J. S. Reekie, Chino.

Resigned—W. T. Barry, Santa Barbara Co.

Transferred—W. E. Carter, from San Francisco Co. to Los Angeles Co.; L. L. Jones, from San Francisco Co. to Tulare Co.; W. Lester Wilson, from Stanislaus Co. to Santa Clara Co.

Legal Defense Indemnity in Malpractice Suits—"Dr. McDavitt, special committee chairman, Board of Trustees of the A. M. A., presented a report which embodied the study made by the committee of legal defense indemnity in malpractice suits. Emphasis was made of the need of co-operation between the administrative directors at headquarters of the Association and the committees on medical defense of the constituent State associations. Attention was called to the action of the Council on Health and Public Instruction in its report to the House of Delegates recommending the separation of all legislative functions from the jurisdiction of the Council. Inasmuch as the House of Delegates approved of this request of the Council on Health and Public Instruction and recommended the organization and establishment at headquarters of a Bureau on Legal Medicine and Legislation with a full-time secretary in charge, the Board empowered the Executive Committee and the General Manager to proceed at once with this undertaking."—*Jour. A. M. A.*, June 10, 1922, p. 1821.

OBITUARY

THOMAS J. COX

Thomas J. Cox of Sacramento, one of the best known and best beloved physicians of this state, died suddenly at his home in Sacramento on July 5. Doctor Cox was born on the old-time Cox ranch on the American River fifty years ago. He was educated in the public schools of California and received his medical degree from Cooper Medical College of San Francisco. In commenting upon Doctor Cox's untimely death, the Sacramento Bee says:

"Deceased was a man of great public spirit, kindly disposition and generous heart. He was ever to the front in everything that made for public good, and for public weal, and for public advancement. His purse was never closed to the appeal of suffering or of want."

Doctor Cox leaves a wife and five children—three daughters and two sons; also a sister, Mrs. James Beach of Fair Oaks.

DEATHS

Jamison, William R. Died in Watsonville, Calif., June 29, 1922, aged 65 years. Dr. Jamison was a graduate of the California Medical College, 1895, and was a member of the California State Medical Society.

Herrick, Albert B., Sr. Died in Santa Rosa, Calif., June 27, 1922, aged 71. Graduate of Medical Department, University of Michigan, June, 1879. Deceased was the father of Albert B. Herrick, Jr., also a physician of Santa Rosa.

Diggins, Edward A. Died at Weimar Hospital, June 29, 1922. Graduate of Cooper Medical College in 1895. Dr. Diggins was a veteran of the Spanish-American and World wars.

Meigs, J. J. Died in San Francisco, July 8, 1922, aged 84. He received his degree of doctor of medicine from Harvard Medical School in 1860. Dr. Meigs was prominent in Grand Army circles, having been present at Appomattox when Lee surrendered to Grant.